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ABSTRACT

This report is intended to help communities identify and implement programs designed specifically for parents. The first chapter, "Characteristics of Effective Prevention Program," by Bonnie Benard, explores program comprehensiveness and intensity, strategies, and planning. The second chapter "Parent Training as a Prevention Strategy," by Kerby T. Alvy, addresses five important issues related to parent training as a community strategy for preventing alcohol and other drug use. The third chapter "Alcohol and Other Drug Prevention Roles for Parents," identifies and briefly describes 10 interrelated roles, and details of each role are offered by nationally recognized experts in the parenting and alcohol and other drug prevention fields. The fourth chapter "Appropriateness and Cultural Competency, Crucial Elements in Parent Training Programs," by Michael Cunningham, addresses a number of elements germane to achieving ethnic appropriateness and developing cultural competency. The fifth chapter "How to Get Hard-To Reach Parents Involved in Parenting Programs," by Karol L. Kumpfer presents a variety of strategies for getting high-risk parents involved in family-focused prevention programs. The sixth chapter "Sample Program Descriptions," lists 23 programs that either have or are in the process of developing components that directly address the issue of alcohol and other drug use. The seventh chapter "Implementing a Parenting Program in Your Community," by David Pines, looks at preparation, implementation, and followup issues. The appendix lists organizations which focus on alcohol and other drugs and organizations which focus on families and children. (LLL)

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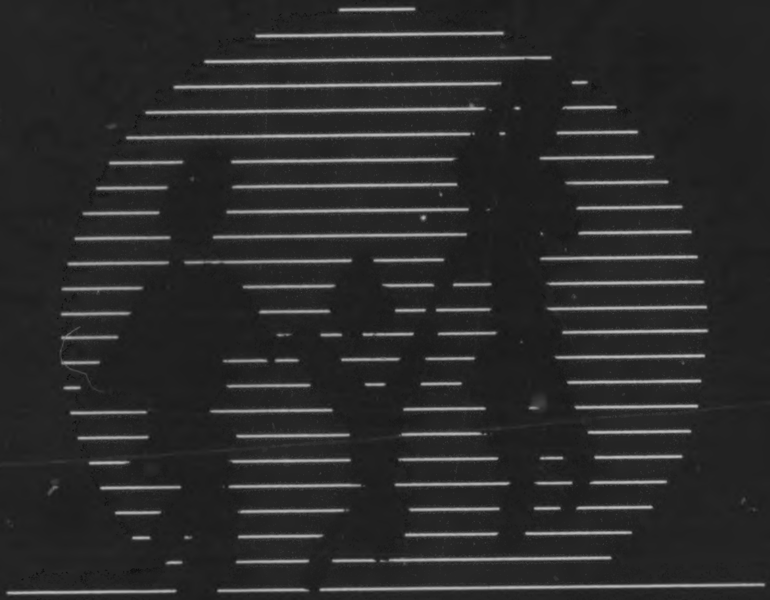

Preventing Alcohol And Other Drug Problems Among Youth In The Family

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PARENT TRAINING Is Prevention

Preventing Alcohol And Other Drug Problems Among Youth In The Family

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Office for Substance Abuse Prevention
5600 Fishers Lane
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Parent Training Is Prevention: Preventing Alcohol and Other Drug Problems Among Youth in the Family

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Contents

Foreword v

Introduction: Parent Training Is Prevention vii

Chapter 1: Characteristics of Effective Prevention Programs 1

Chapter 2: Parent Training as a Prevention Strategy 11

Chapter 3: Alcohol and Other Drug Prevention Roles for Parents 27

Chapter 4: Appropriateness and Cultural Competency: Crucial Elements in Parent Training Programs 79

Chapter 5: How To Get Hard-To-Reach Parents Involved in Parenting Programs 87

Chapter 6: Sample Program Descriptions 97

Chapter 7: Implementing a Parenting Program in Your Community 135

About the Authors 143

Appendix 147

5

Foreword

Parenting is one aspect of a comprehensive approach to the prevention of alcohol and other drug use among youth in America. Parenting is important, but it must be remembered that parents also need support from all aspects of the culture and community. Parents are charged with the responsibility of nurturing and protecting our youth, just as teachers are charged with educating them. Others in the community can support these efforts by providing overall nurturance, support, respect, and encouragement for these important tasks.

Community members can also increase the effectiveness of parents by supporting nonuse norms for youth, by restricting pro-use influences on youth, by setting an example, and by modeling healthy choices and lifestyles. Healthy environments encourage healthy choices and make them easier to sustain. Everyone in the community has a responsibility for reinforcing values and norms and beliefs that foster the healthy and safe development of children and youth.

The implementation of these community actions and parenting techniques will differ among cultures. "Parents" may be defined according to heritage, culture, and ethnicity. Some families, for instance, may rely on the grandmother to establish behavioral policies that are implemented not only by mothers and fathers but by all the aunts and uncles and surrogate brothers and sisters in the neighborhood. Tribal elders may play important roles in the rites of passage from childhood to adolescence among American Indians. Those from Hispanic cultures may define family in the larger context of their entire heritage. Foster parents, institution parents, adopted parents, single parents living in group homes, stepparents, and a wide range of other family patterns have emerged and should be respected within the context of developing, promoting, or implementing parent programs.

Very little research has been conducted with regard to these alternative forms of parenting or parenting within different ethnic groups, so few conclusions about such programs have been incorporated into this guide. However, some core ideas (for example, that children need positive reinforcement and limits) may be implemented within a wide range of settings among a wide variety of cultures, and readers are encouraged to seek creative ways to explore culturally sensitive options for transferring this knowledge.

The most important point to be made is that none of these ideas or programs will be effective without input from the groups selected to benefit from them.

I encourage each of you to continue to explore new and better ways to help prevent alcohol and other drug use among our youth and to support parents and families in their efforts.

Elaine M. Johnson, Ph.D.
Director
Office for Substance Abuse Prevention

Introduction

David Pines, M.Ed.

The purpose of *Parent Training Is Prevention* is to help communities identify and implement programs designed specifically for parents. The guide begins with basic information on prevention, addresses the importance of parenting in family development, provides detailed descriptions of specific roles that parents play in raising alcohol and other drug free children, highlights ethnic and cultural considerations, and concludes with guidelines for program implementation.

The manual helps interested individuals choose from a variety of parent programs available throughout the United States, all of which either currently have, or are developing, components dealing with the issue of alcohol and other drug use among young people. The manual addresses many important issues relevant to program selection. The use of this manual can be the first step in realizing the benefits of prevention training for parents.

PARENT *(noun)*

1. A father or mother
2. A forefather; ancestor; progenitor
3. Any organism that produces or generates another
4. Guardian; protector

(verb) 1. To act or serve as a parent to

PREVENTION *(noun)*

1. The act of preventing

PREVENT *(verb)*

1. to keep from happening, avert
2. to keep (someone) from doing something, impede
3. to anticipate or counter in advance

—*American Heritage Dictionary,*
2nd College Edition

Note: The term drugs, as used in this guide, refers to illicit drugs such as marijuana, cocaine, heroin, and so forth, and any other drugs that are misused. This could include prescription drugs and over-the-counter medications. For youth under age 21, it also includes alcohol.

FAMILY—THE PRIMARY RELATIONSHIP

Parents and children begin life in a profound relationship. Almost immediately, the possibilities of that relationship are affected by every conceivable circumstance. Parents' hopes and dreams for their children are reduced through economic problems, household and domestic issues, financial setbacks, and cultural problems, in addition to the normal problems associated with the modern technological age. Alcohol and other drug use by young people can destroy family communication and relationships.

THE BENEFITS OF PREVENTION SKILLS

To avoid the problems other parents are currently facing, many parents are becoming informed about more effective ways to communicate with their children about alcohol and other drugs. The importance of a nurturing environment for children is evident in the reduced incidence of alcohol and other drug use among children raised in such environments. Parents who enhance their nurturing skills are at a distinct advantage over parents who simply do the best they can. Prevention training helps to enhance these skills.

REACHING PARENTS

Prevention training can be brought to parents in many ways. Parents often work: unions and corporations have employee assistance programs. Parents watch television and read newspapers and magazines: the media can provide public service announcements, and parents can educate youth to analyze commercial advertizing critically. Parents belong to clubs and civic associations: these meetings are good forums for speakers and program initiation. Parents are involved in religious institutions: community projects can begin in these small forums and be shared with the larger community.

NEW OPENINGS

What if a corporation, a community center, a parent/teacher association, a religious institution, or a civic organization trained parents to handle alcohol and other drug issues and problems within their families? What new openings would be created if a community had a plan to help parents build specific, proven skills that would not only decrease the likelihood that their children would use alcohol or other drugs, but also increase the likelihood of their children's success in school, on the job, and in relationships?

Chapter 1: Characteristics of Effective Prevention Programs[*]

Bonnie Benard

The characteristics of effective prevention programs are divided into three broad categories: those pertaining to (1) program comprehensiveness and intensity, (2) strategies, and (3) planning. Each of these categories is explored in turn.

COMPREHENSIVENESS AND INTENSITY

Effective prevention programs are comprehensive in that they address multiple systems and use multiple strategies.

Multiple systems include youth, families, schools, workplaces, community organizations, and media. Multiple strategies might include, for example, providing accurate information, developing life skills, creating positive alternatives, training influential people, and changing community policies and norms.

Comprehensiveness also means involving the whole community in prevention efforts.

In contrast to the usual ineffectiveness of solely school-based prevention efforts, comprehensive examples such as heart disease prevention programs that involved communitywide interventions significantly reduced the risk factors associated with the onset of negative health behaviors, the behaviors themselves, and related morbidity and mortality.

Prevention should address all youth and not just those identified as high risk.

Although much research has focused on identifying youth at risk for alcohol and other drug problems, other researchers have cautioned against interventionist prevention programs. The latter view is supported by several

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[*] Note: Adapted from "Bonnie's Research Corner," *Prevention Forum* 6(4), June 1986.Perhaps the most important conclusion to be drawn from over a decade of prevention research is that prevention efforts that focus on a single system or use a single strategy probably will have little impact because many of the causes of alcohol and other drug problems are related to personality, environment, and behavior.

points. First, adolescence is a high-risk time for everyone. Many adolescents engage in health-compromising behaviors such as using alcohol and other drugs. Second, labeling high-risk children and designing different programs for them might stigmatize them. This could make these children more likely to become involved with alcohol and other drugs. Third, many segments of the grassroots parent movement oppose the social and psychological testing and evaluation procedures necessary to identify youth at risk.

Effective prevention programs are part of a broader, generic prevention effort to promote health and success.

Research (e.g., Jessor 1984) indicates that health-compromising behaviors tend to be interconnected and to have common antecedents. According to Jessor, prevention efforts that focus on changing only one behavior (e.g., alcohol and other drug use) probably will not work.

Intensity means designing programs of duration, with interventions beginning early and continuing through the life stages.

The "protective factor research" of Werner and Smith indicated that resilient children received a great deal of attention in their first year of life, thereby giving them "a basic trust and a sense of coherence" in relating to their environment (Pines 1984).

Effective programs provide sufficient prevention efforts (adequate time per strategy and adequate number of strategies).

Because prevention activities are designed to change fundamental attitudes and behaviors, sufficient opportunities for these activities must exist. If anything has been learned from the last decade, it is that solitary prevention efforts do not work.

Prevention activities should be integrated into family, classroom, school, and community life.

Integrated activities remain more an ideal than a reality for many programs. However, the positive outcomes of several projects can be attributed in part to their emphasis on integrating a prevention strategy into either daily life in the classroom or the total school and home environments.

Effective prevention programs build a supportive environment that encourages participation by the whole community and fosters a sense of community responsibility.

It is important to identify the characteristics of positive family and school environments. Environments in which children are given both opportunities to participate and responsibilities produce positive behavioral outcomes.

STRATEGIES

INFORMATION

Effective prevention programs address knowledge, attitudes, and skills as a focused set.

Prevention efforts should provide alcohol- and other drug-specific knowledge and skills and foster changes in attitudes.

The failure of approaches limited to affective education (e.g., education on self-esteem), in which alcohol and other drugs often were not even mentioned, suggests that attitudes and skills specifically related to alcohol and other drug prevention are needed.

Effective prevention programs focus on the prevention of tobacco, alcohol, and marijuana use.

Use of tobacco, alcohol, or marijuana is associated with the use of the other two. The use of tobacco, alcohol, and marijuana often precedes the use of other illicit drugs, including cocaine and heroin.

Effective prevention programs pay attention to the salience of information and education materials.

The materials used in a school prevention effort should be relevant and of interest to the audience. More specifically, they should have the following attributes:

- Ethnic and cultural sensitivity
- Appeal to youths' interests
- Emphasis on short-term outcomes important to youths as well as on long-term effects
- Appropriate language and reading level
- Appealing graphics
- Usefulness in different modes of learning (auditory, visual, etc.)
- Appropriateness to age and developmental level

The issue of age appropriateness has received much attention in prevention literature. The consensus seems to be that sixth or seventh grade, a critical transition period, is an appropriate time to implement a social skills model program. However, in view of the downward trend of age of first use and other results of research (e.g., a 1980 national survey of 3.7 million 4th through 12th graders by *Weekly Reader Magazine*) 4th grade, especially in many urban areas, appears none too early for introducing knowledge, attitudes, and skills related to preventing tobacco, alcohol, and marijuana use. Some prevention programs target children as young as 3 to 5 years old.

ALTERNATIVES

Effective prevention programs provide positive alternatives that serve functions similar to or more highly valued than those served by health-compromising behaviors. The goal is for youth to say "no," so give them other activities they can say "yes" to.

According to some problem behavior theorists, alcohol and other drug use and additional problem behaviors can serve important psychosocial developmental functions that mark an adolescent's transition to adulthood. They allegedly facilitate a sense of community among peers, opposition to the norms and values of the larger society, and coping with feelings of inadequacy and stress. These behaviors are often wrongly seen by youth and adults as rites of passage into adulthood. Prevention programs therefore must provide and reinforce positive, healthy substitutes for health-compromising behaviors. Such alternatives include local service club youth programs and mentoring projects. Good prevention can also include community action groups in which people unite around specific issues.

LIFE SKILLS

Effective prevention programs should incorporate the following life skills: communication, problem solving and decisionmaking, critical thinking, general assertiveness, resistance, peer selection, low-risk choice making, self-improvement, stress reduction, and consumer awareness.

Often referred to broadly as **social skills** or **social competence**, **communication** can also be defined as the ability to cope effectively with interpersonal relationships. Programs that enhance communication skills typically cover verbal and nonverbal communication, guidelines for avoiding misunderstandings with parents and friends, and heterosocial (boy-girl relationship) skills.

Social **problem-solving and decisionmaking skills** are beneficial for young children. The hypothesis is that problem-solving skills contribute to the development of an internal locus of control, which in turn builds self-efficacy and self-esteem and ultimately militates against problem behaviors such as alcohol and other drug use.

Critical thinking can be defined as problem solving applied to a specific subject. It can form a bridge between the artificially separated emotional and intellectual domains of learning. In the past decade, **general assertiveness** training has been an essential strategy for building self-efficacy in many prevention and intervention programs. The short-term outcomes of evaluated programs have been positive; long-term outcomes have been mixed. Gilbert Botvin's successful Life Skills Training Program (Cornell University) combines general assertiveness with a specific focus on assertiveness skills related to tobacco, alcohol, and other drug prevention. (Dr. Botvin's research has focused primarily on tobacco use. The alcohol studies are questionable.)

Although **resistance skill** training is an essential component of a prevention program, the following cautions seem in order. First, resistance skills should not be the only skills taught. Adolescents need other life skills as well if they are to be healthy nonusers of alcohol and other drugs. Second, the fact that many children may not want to refuse is often overlooked.

Peer selection may be even more valuable than resistance skills.

Actual experience in designing and implementing a **self-improvement** project is part of Botvin's Life Skills Training Program. The students identify a skill or behavior that they would like to change or improve and develop a long-term goal (8 weeks) and short-term objectives (1 per week) to meet that goal. This process is believed to build self-efficacy and promote internal locus of control.

Research findings suggest that **stress** is a variable leading to initiation of alcohol and other drug use, especially tobacco use. Increasingly, **consumer awareness** is an important element of prevention programming. The ability to analyze and evaluate media messages and advertising is crucial if youth are to resist the powerful pro-use message promulgated through the media and other forms of advertising.

TRAINING BY INFLUENTIAL PEOPLE

Effective programs are delivered by credible, skilled trainers/implementers.

Credibility and skill include the following attributes: good preparation, honesty, effective communication, group facilitation, comfort with the materials and the audience, supportive personalities, appropriate behaviors and social interaction, and the ability to lead role rehearsals.

CHANGE OF SOCIAL POLICY/COMMUNITY NORMS

Prevention programs should promote clear, firm, consistently and equitably enforced, and carefully communicated alcohol and other drug policies.

Studies of effective schools and healthy families suggest the efficacy of this course of action.

Effectiveness depends on addressing cultural norms pertaining to the use of alcohol.

Alcohol is problematic in that it is a culturally accepted drug. The society must change prevailing beliefs, encouraged by advertising, that drinking is the only way to have fun, relax, be an adult, and be cool. Research results from community heart disease prevention programs show that community attitudes toward health-compromising behaviors can be changed.

Prevention programs should promote school success.

The failure to learn in school is probably the biggest single factor leading to alcohol and other drug use and other problem behaviors (Kellam 1982). Among the educational reforms he and others advocate are the following: reduce class size to fewer than 25, design curriculums that address each child's abilities and needs, enrich curriculums through varied activities that address different learning styles, and legitimize and reinforce a parent-teacher partnership.

Effective prevention promotes social and economic changes that create more opportunities for education, employment, recreation, and self-development.

The social problems that contribute to alcohol and other drug use must be addressed. This is a complex community issue. Although it is easy to accomplish, change takes a great deal of planning and patience. In the classic public health model of prevention, work must focus not only on the agent (the drug) and the host (the individual user or potential user), but also on the environment in which the behaviors occur. It is important to create linkages among social science agencies, law enforcement and criminal justice agencies, housing authorities, schools, community action groups, and other key community groups.

PLANNING PROCESS

Effective programs follow a sound planning process consisting of needs assessment, goal identification, implementation, management, evaluation, and replanning.

Lack of adequate implementation has been repeatedly cited as contributing to the poor outcomes of many prevention programs. However, little research has been focused on the actual planning process and on identifying the planning stage at which programs are most likely to fail. Because prevention programmers cannot afford to wait for research results to achieve this level of sophistication and specificity, they will have to use experience, good planning, and problem-solving skills as a guide.

Program planners must collaborate.

Inadequate implementation often reflects the lack of involvement of key actors. An effective planning effort elicits the active participation of all local systems including parents, teachers, police, school administrators, youth, businesses, churches, voluntary agencies, and government.

The research literature often calls for more collaboration among prevention professionals from various disciplines (mental health, public health, alcohol and other drug abuse, education), as well as between prevention researchers and program planners. Yet relatively little attention has been given by researchers to the importance of developing a collaborative community base.

Effective prevention programs have realistic, multiple, and measurable goals.

Unrealistic, narrow, poorly defined, and unmeasurable goals may be part of the reason for poor program outcomes. Program planners must be realistic in establishing goals and remember that effecting behavioral change requires a long-term commitment and a community-wide effort. Weisheit (1983) states that goals should identify not only long-term outcomes but also process measures and short-term outcomes, such as increased levels of parent and community involvement in the program, academic success, and increased student-teacher interaction.

Effective programs evaluate effectiveness. Lack of or inadequate evaluation is a frequent criticism of prevention programs.

Evaluation depends on selecting realistic and measurable goals and on implementing activities that can actually effect these outcomes. Researchers have noted the need for multiple evaluation measures and instruments, longitudinal design, and cost-benefit analysis.

Flexibility is necessary for program success.

Effective prevention programs make recommended changes as a result of evaluation feedback. They also are dynamic, adapting to changes in funding level, leadership, and constituency.

Careful marketing enhances program success.

Marketing is increasingly important to the success of any program. Once people see the value of comprehensive programs, there must be community buy in. A major part of good marketing is including other groups such as the business community, the clergy, community groups, and educational institutions, among others.

The saying "an ounce of prevention is worth a pound of cure" is one way of describing an effective prevention strategy. The Federal Head Start Program costs approximately $3,000 per student per year. Graduates of the program are more likely to complete school, get a good job, and stay out of the criminal justice system. The cost of keeping one person in prison is more than $20,000 per year. This shows that prevention provides an asset that few social programs can claim: cost-effectiveness. Planners can capitalize on this.

Probably few, if any, prevention programs have all the characteristics enumerated in this chapter. However, an operational assumption for planners is that the likelihood of creating a successful prevention program increases in proportion to the number of effective programming attributes employed.

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Chapter 2:
Parent Training as a Prevention Strategy

Kerby T. Alvy, Ph.D.

A healthy lifestyle is a great asset. An alcohol- or other drug-dependent lifestyle is destructive to the people who engage in it, their families, and the entire community.

Parents can do many things to help their children avoid alcohol or other drug use. When parents are successful, they perform a service from which everyone benefits.

As with most of the roles they play in preparing children to be healthy and productive adults, parents customarily receive little or no training in alcohol and other drug use prevention. This chapter is designed to make such training possible by providing communities with the latest information on alcohol and other drug problem prevention training programs for parents. With this knowledge, a community can decide which programs are appropriate for its needs and how to bring these programs into neighborhoods.

Communities that take advantage of these opportunities are in the vanguard in our Nation's struggle against drugs. They supply the front-line warriors—parents—with the preparation needed to wage a successful home campaign.

This chapter addresses five important issues related to parent training as a community strategy for preventing alcohol and other drug use. The first three—parents' contributions to child development, the variety of functions parents serve as they raise their children, and the forces that influence parents' functioning—provide a perspective on what can be accomplished through parent training programs. The fourth issue is defining effective parenting on the basis of research. Finally, the chapter addresses the factors that place children at risk for abusing or becoming dependent on alcohol and other drugs. In analyzing these issues, the discussion draws on the latest research findings on child development, child-parent relations, parental role functioning, and the causes and consequences of alcohol and other drug use.

PARENTS' CONTRIBUTIONS TO CHILD DEVELOPMENT

Parents are an extremely important influence on children's development, but they are not the only influence. Internal (biological) and external (environmental) forces also shape the development, characteristics, and behaviors of children (box 1).

Box 1
Determinants of Child Development

Internal Biological Determinants

- A. Genetic
- B. Nongenetic

External Environmental Determinants

- A. Social/psychological
- B. General milieu

The pivotal importance of parents lies in their contribution to both the biological and environmental forces.

The biological factors are of two general types, and parents are involved in both. Parents pass on the genetic code that determines such characteristics as gender, height, and physical appearance, and they greatly influence such psychological attributes as temperament, personality, and the rate of progress through various developmental stages. There is also evidence that genetic factors may predispose some children to alcohol and other drug use.

The nongenetic forces include the mother's use of alcohol or other drugs during pregnancy, a lack of oxygen during the birth process, and the malfunctioning of an organ or gland. All these can result in modifications of the child's biological makeup.

The environmental factors that influence development are the child's immediate social/psychological environment (which usually consists of parents, child care personnel, siblings, relatives, teachers, peers, and neighbors) and the socioeconomic and cultural world in which the child develops. Parents play a significant part in creating this world; their economic resources partly determine where and how the child lives, and the cultural values they transmit are a significant influence.

Although parents are clearly the major influence on a child's development, it is important to remember that their effectiveness has limits. Many biological and environmental factors affect characteristics and behaviors. The social and cultural world is not entirely in the parents' control, and many people other than parents help to shape the child's immediate social/psychological environment. Parents must keep in mind that their contribution to child development is both powerful and finite.

PARENTAL FUNCTIONS IN RAISING CHILDREN

An analysis of what parents actually do for their children reveals five interrelated general functions (box 2).

Box 2
General Parenting Functions

Breadwinning
Home care
Protection
Guidance
Advocacy

The **breadwinning** function entails the provision of basic resources such as housing, utilities, appliances, clothing, food, health services, transportation, recreation, and educational materials. Parents' ability to perform this function is affected by their occupations, education, and inheritance. Their ability to provide can affect their ability to carry out other functions.

When the provision of basic necessities is a serious and chronic problem, they may have less energy and ability to fulfill other parental responsibilities. The amount of time devoted to breadwinning also influences parents' performance of other duties. Today, most families in the United States have two parents in the work force, and many parents spend less time than they would like with their children.

Home care includes such basics as home maintenance, nutrition, and sometimes car maintenance. It also comprises the budgeting, management, and investment of money and the overall organization and scheduling of home life. Home care is greatly influenced by parents' breadwinning capabilities. When both parents are involved in breadwinning, less time is available for carrying out the home care function.

Child protection is the basic parental function of keeping children safe from an array of possible harms. This function includes protecting children from bodily harm by organizing a safe home environment (child-proofing); sheltering children from rain, wind, and snow; helping to prevent physical or sexual assault; and guarding their developing sense of personal adequacy and competence. It also includes protecting children from various types of peer group harm such as overtures and pressure to engage in illegal or antisocial activities. Another type of harm, with which ethnic minority parents are particularly concerned, is the damage that racial and ethnic discrimination can do to a child's developing ethnic and cultural identity. Parents carry out the protective function through a variety of means, including the example they set by protecting themselves.

All parents, throughout history, have had to protect their children. Parents now have to be concerned about the physical, social, and psychological dangers of the use of such drugs as alcohol, cigarettes (nicotine), marijuana, heroin, and cocaine. The protective function must now be adapted and enhanced to address these increased threats to children's safety.

The **child guidance** function is the responsibility to facilitate, guide, and direct the various aspects of development. Child protection and child guidance are complementary in that one ensures the opportunity for development and the other directs its course.

Parents are involved in guiding all aspects of their children's development, whether or not they are aware of it. They affect physical development by feeding, cleaning, and dressing children; attending to their health care and needs for rest and sleep; administering medical assistance; and arranging and taking children to appointments with health professionals. Parents affect emotional development by nurturing children and providing them with love and acceptance. They affect social development by setting limits and helping children learn socially appropriate behavior. They are influential in their children's intellectual development by providing in-home learning opportunities. Parents also instill moral, religious, and cultural values, thereby influencing these aspects of their children's development. Many ethnic minority parents are especially conscious of the need to pass along their ethnic history and encourage ethnic pride.

The child guidance function is carried out by communicating (verbally and physically), sharing information, and providing parental models consistent with the characteristics and values parents want to promote.

Success in child guidance is strongly influenced by performance of other functions. For example, being consumed with breadwinning, home care, or protection leaves little time or energy to refine one's guidance capabilities.

Most of the training programs mentioned in this book were created to help parents carry out their child guidance duties. The programs were designed to give parents basic child development information and basic communication, limit-setting, and problem-solving skills. In focusing on guidance, these programs seek to improve the overall quality of parent-child relations and create warm and secure home environments. Good communication and effective limit setting and problem solving seem to help serve as protective buffers against alcohol and other drug use.

Parents are the primary connection between their children and other persons and societal institutions. Because it is parents who introduce children to the extended family, neighbors and friends, television, child care institutions, schools, and health facilities and practitioners, parents perform an important **advocacy** function. Children, especially babies and preschoolers, are not always capable of communicating their own needs. Parents must not only bring their children into contact with, but also make sure that their children's needs are met by, other persons and institutions. Parents also have to help their children understand the purposes and values of various institutions. Again, ethnic minority parents face particular challenges in carrying out this function, as they often have to be extremely sensitive to the ways in which these institutions view them and their children.

THE FORCES THAT INFLUENCE PARENTS' PERFORMANCE

As it is with children, so it is with parents: many forces, both internal and external, influence how parents develop and behave. Research on parental functioning has identified a wide array of contributing factors (box 3).

Box 3
Determinants of Parental Functioning

Parenting knowledge, attitudes, and skills
Parents' characteristics
Child's characteristics
Stress/support
Work characteristics
Household characteristics
Marital characteristics
Cultural and religious values

Obviously, people's knowledge, attitudes, and skills related to parenting influence their approach. Knowledge about child development helps parents know what to expect from their children; it helps them to be realistic about what children can and cannot do. Effective verbal communication skills also help parents learn about their children. Skills for encouraging and appreciating children's behavior enable parents to teach children what is socially appropriate and valued. Decisionmaking and problem-solving skills assist parents in

24

resolving conflicts so that all parties can continue to live in relative harmony. Many of the skills that enhance child-parent relations are the same skills that enrich all human relationships, and as with human relations skills in general, child-parent skills need to be learned and refined.

People's unique characteristics also influence their performance as parents. Parents change and evolve. Such parental traits as maturity and intelligence can help or hinder relationships with children. When children and parents are on the brink of battle, a more mature and intelligent parent may be better equipped to avoid an escalation into open warfare.

Parents also differ in their temperaments and personalities. Some people are impulsive, others are reflective; some are introverted, others are extroverted; some have inner control, others are controlled by outside forces. A particular parent's temperament or style can mesh nicely with that of a particular child, but some parents and children are not well matched. An outgoing, extroverted parent might be stimulated by a child who is especially curious and active, whereas a more introverted parent might find the same child to be irritating and fatiguing.

Parents' health status also contributes to their performance. Any parent suffering from poor health or fatigue can react negatively or indifferently. Turmoil over one's identity, sexuality, spirituality, or career can have adverse effects on parental expectations and behavior. Emotionally unstable parents often find it difficult to have good relationships with their children. Parents who abuse alcohol and other drugs are at great disadvantage in raising and relating to children. They not only fail to establish sound relationships but they also provide models of self-destructive behavior. Of course, parents with chronic problems have the most difficulty keeping up with the activity and developmental changes of children.

Children's unique characteristics—biological and psychological—also help to determine how their mothers and fathers perform as parents. Children's personalities differ at birth, and individuals change rapidly as they progress through developmental stages. Pliant and cooperative children can become defiant and destructive as they play out some internal developmental need. Keeping up with children's developmental swings, and learning how best to manage them, are continuous challenges. Some parents do better at different stages than others, and some parents deal with certain aspects of development better than others. Parents' functioning is determined partly by their children's temperaments and willingness or ability to be influenced by their parents.

Stress—from a variety of sources—affects a parent's functioning. Poverty, discrimination, financial problems, social isolation, job changes or losses, death, illness, inadequate child care, and divorce or separation all influence the abilities of parents. Symptoms of prolonged or excessive stress such as that associated with depression and health problems sometimes set the stage for child abuse.

On the other hand, parents who receive adequate support from friendships, social networks, relationships, and employment situations are more likely to be psychologically and physically healthy and are, therefore, more positive in their approach to raising children.

Job satisfaction can influence parenting in a variety of ways. A stimulating job can leave a parent with a sense of accomplishment that results in serenity and enjoyable interaction with children. Those who are always absorbed by their work, however, can be irritable and unavailable. Lack of employment often leads to family conflict. Lack of control at work can lead to overcontrol at home.

The characteristics of the household are also influential. Family size affects individual parent-child relationships. Large families with single parents have a very different dynamic from families with two parents and two children. Step-families often have special needs and problems. Even the size of the dwelling can affect parental functioning.

The quality of the relationships among the adults in a home also has significant effects. Two parents or other adults in a household working within a warm and fulfilling relationship are more likely to raise healthy and productive children. The absence of support from a spouse or significant other(s) can greatly influence parenting, as can incompatibility between parents.

Cultural and religious values and traditions also help to determine how parents function. Although laws generally reflect institutionalized standards of behavior for a given society, values differ among cultures and ethnicities. In some cultures, parents would be considered irresponsible if they did not strike or shame a child for disobeying a parental request or showing disrespect. In other cultures, hitting children is considered disgraceful. Some parents conform to cultural and religious traditions more than others. Most of us are influenced by cultural norms, and all of us are bound by laws about physical interaction with children, such as abusing a child.

The list of factors that affect the performance of parents is not endless, but it is extensive. The success of parent training programs or any other attempts to alter parental behavior depends on the number of determining factors addressed.

EFFECTIVE PARENTING: A DEFINITION

What constitutes effective parenting? Possible answers may be found in the research literature on parent-child relations. It is important to keep in mind that this research is an ever-evolving scientific endeavor influenced by what scientists choose to study and by the state of the art in scientific methodology.

Scientists choose to study specific subjects as a result of a wide range of factors, including what the Federal Government considers worthy of support and availability of funding for projects. Much Federal support for research on parenting has been stimulated by specific concerns and problems and has focused on specific parenting functions. Most research has been done on the effects of the child guidance function and less on breadwinning, home care, protection, and advocacy.

Within child guidance, some subjects have received more attention than others; for example, more is known about the effects of parenting practices on children's emotional, social, and intellectual development than about effects on children's spiritual and cultural development. A growing national concern about child abuse and neglect stimulated Government support for the scientific study of the effects of abusive parenting, which mainly examines the parent's role in guiding children's social and emotional development (Belsky 1984; Wolfe 1985). Because there has been no comprehensive, well-funded research program on the general influence of parenting on all facets of child development, research findings can only suggest possible definitions of effective parenting.

Research methods go through periods of favor and disfavor. Observational studies have been advocated and criticized, and so have laboratory experiments. As methods of statistical data analysis have progressed, studies that applied less sophisticated methods have been criticized (Alvy 1987; Maccoby and Martin 1983).

RESEARCH FINDINGS

Some consistent findings suggest that certain approaches to parenting are more productive than others. These findings emerged from studies in which parenting attitudes and practices were analyzed in relation to various emotional and social characteristics of children, including self-esteem, emotional stability, and social adjustment (Clarke-Stewart 1988; Maccoby and Martin 1983; Martin 1975; Rohner 1987).

Two major dimensions of parenting seem most important: love (acceptance or rejection) and control (permissiveness or restrictiveness) (box 4).

Acceptance or warmth consists of being satisfied with a child's abilities and characteristics, seeking out and enjoying the company of the child, providing much positive reinforcement through verbal and physical means, and being sensitive to the child's needs and points of view. Parental rejection or hostility consists of the reverse: not being satisfied with the child, criticizing his or her characteristics and abilities, not enjoying or seeking out the child's company, failing to provide much positive reinforcement, and being insensitive to the child's needs and points of view.

Box 4
Parental Love and Control

Love: Acceptance vs. Rejection

The Accepting Parent	The Rejecting Parent
Is satisfied with child	Is critical of child
Seeks out and enjoys child	Does not seek out or enjoy child
Provides much positive reinforcement	Provides little positive reinforcement
Is sensitive to child's needs and viewpoints	Is insensitive to child's needs and viewpoints

Control: Restrictiveness vs. Permissiveness

The Restrictive Parent	The Permissive Parent
States rules clearly and provides consequences for violations	Does not state rules clearly or provide consequences for violations
Firmly or consistently enforces rules	Does not firmly or consistently enforce rules
Rarely gives in to coercive demands	Is likely to give in to coercive demands

Many desirable child characteristics, such as high self-esteem and emotional stability, are often associated with having parents who are primarily accepting and warm in the above ways. Negative characteristics are often consequences of rejecting and hostile parenting. These phenomena—the positive power of parental warmth and the destructiveness of rejection—have been observed in groups throughout the world (Rohner 1987).

Raising children requires setting limits on and guiding their behavior into socially acceptable forms. In many research studies, these limit-setting and guidance functions are defined as parental control. Permissive parents do not clearly state rules and the consequences of rule violations, do not firmly or consistently enforce rules, and tend to give in to children's coercive demands. Restrictive control consists of clearly stating rules and consequences for violations, firmly and consistently enforcing the rules, and rarely giving in to children's coercive demands. The effects of permissive and restrictive control appear to depend on the amount of acceptance and warmth in the parent-child relationship. Accepting, warm, and at least moderately restrictive parenting seems to have the most desirable effect on children's overall development.

PRODUCTIVE AND DESTRUCTIVE PATTERNS

Research shows that parenting patterns encompass other characteristics in addition to acceptance/rejection and permissiveness/restrictiveness (Maccoby and Martin 1983). Parents also differ in their responsiveness to their children's behavior, how demanding they are of mature behavior from their children, and the quality and depth of their daily involvement with their children. All of these qualities, considered together, constitute a pattern of parenting. Two parenting patterns that deserve close attention are the productive and destructive patterns (box 5).

Box 5
Productive and Destructive Parenting Patterns

A productive parenting pattern is characterized by:

High parental acceptance
Moderate to high restrictiveness
Insistence on mature behavior
High responsiveness
High positive involvement

A destructive parenting pattern is characterized by:

Low acceptance
Unyielding restrictiveness
No insistence on mature behavior
Inconsistent responsiveness
Primarily negative involvement

Parents who follow the **productive pattern** are highly accepting, expect mature behavior, and provide clear standards. They firmly enforce rules and standards and use commands and sanctions when necessary. They encourage their children's independence and individuality and engage in open communication with children, listening to the children's points of view, as well as expressing their own. They also recognize their children's rights as well as their own.

Numerous studies show that this pattern is associated with independence, competence in social and academic arenas, appropriate self-assertiveness, social responsibility, ability to control aggression, self-confidence, and self-esteem. Researchers have concluded that this pattern appears to be an optimal parenting pattern for helping parents to raise children who do not require constant supervision and external constraints (Maccoby and Martin 1983).

In the **destructive pattern**, parental demands on children are not balanced by acceptance of children's needs or demands. Children have needs that parents must fulfill, but parents who follow the destructive pattern place strict limits on children's expression of these needs. In extreme cases, children are not allowed to speak until they are spoken to. Parental demands take the form of edicts. Rules are not discussed in advance or arrived at by consensus or bargaining. Parents attach strong value to their authority and suppress children's efforts to challenge it. When children deviate from parental requirements, fairly severe—often physical—punishment is likely to be employed.

This pattern seems to cause children to withdraw, to avoid taking social initiative, and to lack spontaneity. Evidence also links this pattern of parenting to low self-esteem and a feeling of lack of control over one's environment. This pattern may produce overly aggressive children or unassertive children.

When parenting programs are designed on the basis of the latest scientific evidence, they promote the productive pattern of parenting. The vast majority of contemporary programs do promote and teach ideas, values, and skills consistent with that pattern.

RISK FACTORS FOR ALCOHOL AND OTHER DRUG USE

At each of the stages of alcohol and other drug use (initiation/beginning use, continuance, cessation, and relapse), a young person is influenced by various internal and environmental factors (Huba and Bentler 1982). The intimate support system of family and friends is believed to be a particularly important influence in the initiation/beginning use stage.

Research on risk factors is quite varied (DHHS 1987; Hawkins et al. 1986; Kumpfer 1987). It includes studies on the family backgrounds of alcohol and other drug users, a few longitudinal studies in which children were observed during their early years and during their teen years, and a very recent study in which teenagers were followed into adulthood and the later effects of their teen drug use explored. Research includes studies in which the family backgrounds of currently drug-dependent youth are the focus, and surveys of larger segments of the youth population in which some data are obtained on the family backgrounds of both drug-involved and non-drug-involved youth.

Several recent studies provide extensive information on the family, parent, and child characteristics of families in which one or both parents are alcohol or other drug dependent and where the researchers had close relationships with all family members through an intervention program that sought to modify problematic parent, child, and family functioning (Kumpfer 1987). Many fairly recent studies explore the potential genetic and biomedical correlates or predispositions to drug dependency.

Researchers have identified factors that appear to put children at high risk for alcohol and other drug use initiation and continuation. The available research does not allow for definitive conclusions on the relative contributions of the various risk factors. It is not known which risk factors are most important for any particular child or group of children. It is reasonable to assume that children affected by many of these factors are more likely to enter into and continue alcohol and other drug use than children who face fewer risks. The identified risk factors are listed in box 6. Each is discussed more extensively in the text that follows.

Box 6
Family Risk Factors for Alcohol and Other Drug Use

Parental dependency and family history of dependency
Parental psychological and social dysfunction
High levels of family conflict
Family social isolation and antisocial values
Special needs infants/special problem children
Nonnurturant and ineffective parenting

PARENTAL DEPENDENCY AND FAMILY HISTORY OF DEPENDENCY

Recent research has led to a search for biological markers of genetic susceptibility (DHHS 1987; Kumpfer 1987). It is hoped that the discovery of specific neurophysiological, neuropsychological, and biochemical markers will confirm the hypothesis that some people have genetic predispositions for alcoholism and other drug dependencies. Such discoveries could result in biologically mediated interventions to help prevent these problems. For example, medical research can be directed to identify biologic markers to target high-risk individuals for prevention services.

The biological markers that have been discovered thus far have suggested that the higher probability of alcoholism and other drug dependencies among children of dependent parents has to do with their unique reactions to alcohol and other drugs. For some individuals, alcohol seems to have increased normalizing, stress-reducing, and pleasurable effects. In addition, these individuals appear to experience fewer negative effects of intoxication from the same amount of drugs. Because of these unique effects, genetically predisposed individuals may experience more reinforcement for continued use. If so, this would help explain a greater susceptibility to alcohol and other drug addiction.

The higher likelihood of alcohol and other drug use among children of alcohol- and other drug-dependent parents probably is also a result of the home environment. Children as young as 5 years of age who are exposed to frequent family alcohol and other drug use have higher expectations for using drugs themselves. Alcohol- and other drug-dependent parents have many problems and usually are less effective than other parents in all spheres of childrearing. They frequently are very poor managers of home life in terms of home care, child protection, child guidance, and child advocacy. They do a poor job of supervising children at home and monitoring their whereabouts in the community. They spend less time in structured and planned activities with their children and appear limited in their ability to involve themselves meaningfully and emotionally with their children.

Although it is not known exactly how hereditary and environmental factors operate, evidence indicates a higher likelihood of alcohol and other drug problems in children of dependent parents, and especially male children of alcohol-dependent parents. However, through counseling and other intervention strategies, many of these children never begin to use alcohol or other drugs and therefore do not develop alcohol or other drug problems.

HIGH LEVELS OF FAMILY CONFLICT

Researchers and clinicians who have worked closely with alcohol-and other drug-dependent parents and their families have observed "amazingly high" degrees of regular daily conflict. As one observer noted, "family war appears to be the norm, rather than an isolated event, as in more supportive families" (Kumpfer 1987). High degrees of family conflict have also been observed in homes of children who use alcohol and other drugs but have non-drug-dependent parents.

FAMILY SOCIAL ISOLATION

Alcohol- and other drug-dependent parents are more likely to create families that are socially isolated within their communities (Hawkins et al. 1986; Kumpfer 1987). Their social isolation is believed to stem partly from their need to maintain protective boundaries and partly from community rejection. Their isolation causes these families to receive less help and support from others. Either they do not try to make friends in their communities or they feel they cannot have traditional friends.

In addition to condoning the use of alcohol and other drugs, these families appear to have less respect for authority or tradition than most people do and to hold such beliefs as "the ends justify the means." They are less interested in education and academic achievement and in religious, cultural, and community involvement.

SPECIAL NEED INFANTS/SPECIAL PROBLEM CHILDREN

Accumulated evidence shows that children of parents dependent on alcohol or other drugs have special needs and problems. Infants from these families have been shown to have a higher probability of difficult temperaments, hyperactivity, neurological deficits, and learning disabilities (Kumpfer 1987). The greater needs of these infants place greater demands on parents and require exceptionally sensitive parenting to mitigate longer term developmental problems.

Preschool and elementary school age children of alcohol- or other drug-dependent parents have also been observed to be more likely to display a wide range of problematic behaviors at home and in school, such as having temper tantrums, displaying aggression, lying, screaming, and disobeying. It should be noted that children of non-drug-dependent parents have also been observed to have these problems.

Regardless of parental alcohol or other drug dependency, young children who are seen by their teachers as extremely aggressive, or aggressive and shy, are much more likely later to develop social, psychological, and alcohol or other drug problems (Alvy 1987).

Older children of alcohol- or other drug-dependent parents have been found to have difficulty controlling their tempers and to be more likely to fight at school. These patterns appear to repeat the sort of anger control and conflict resolution problems modeled by the parents.

Children in these families are less than normally bonded or attached to the overall society (Hawkins et al. 1986). They are therefore more likely to experience rejection and failure at school and to drop out of school—events that have been found to be related to teen alcohol and other drug use.

These children also appear to have more difficulty than other children in identifying and expressing their feelings. Their emotions, which are rarely validated by their parents, are painful and ambivalent. Characteristic feelings include resentment, embarrassment, anger, fear, insecurity, loneliness, and depression. These children have few friends and believe they lack the ability to make friends.

The many temperament, personality, and behavior problems that have been found in children who eventually use alcohol and other drugs and who continue to use them appear to be more characteristic of children of alcohol- and other drug-dependent parents.

NONNURTURANT AND INEFFECTIVE PARENTING

Children who experience rejection, rather than warmth and acceptance, from their parents appear to be at greater risk than other children for alcohol or other drug use. Parents who have unrealistic expectations about their children's abilities, communicate with them in abusive ways (threatening, chastising, belittling, and criticizing), and use coercive limit-setting and disciplinary methods, increase the likelihood that their children will use alcohol or other drugs.

Research also suggests that productive parenting patterns have the opposite effects. Parents who are warm and accepting, who express realistic expectations about their children's abilities, who are diligent and effective in supervising and monitoring children, whose limit-setting methods are noncoercive, and who spend time with their children, are much less likely to raise alcohol or other drug users.

CONCLUSIONS

Research findings offer strong support for the notion that parents can play important roles in orienting children toward healthy, drug free lifestyles.

Parents are the most important, although not the only, influence on children's developing lifestyles. Their influence can be helpful or harmful.

The most harmful parents are those who themselves have alcohol or other drug problems. Their problems and ineffectiveness make it hard for their children to grow in a healthy way. These parents clearly need to help themselves first. As they are helped to end their alcohol or other drug problems and change their lifestyle, they must also be taught to be more effective as parents.

The most helpful parents are those who are not dependent on alcohol or other drugs **and** who use a productive parenting pattern. They are embodiments of a healthy lifestyle, and they relate to their children in a way that makes that lifestyle appealing and rewarding.

The goal is to help more parents become healthy role models for their children. One way to do this is to provide more parents with the resources to employ the productive parenting pattern.

The parent training programs listed in this manual are examples of the kinds of resources now available. Most of them emphasize the values, ideas, and practices of the productive parenting pattern. Some of these programs were created before the Nation began to regard parent training as a way of helping to prevent alcohol and other drug use among our young. Some programs, therefore, do not focus attention on the specific roles that parents can play in preventing their children from using alcohol or other drugs. Rather, they take a broader view in promoting the productive parenting pattern, which appears to buffer children against alcohol and other drug use.

It is certainly possible to incorporate specific strategies for preventing alcohol and other drug problems into programs that take the broader view, and such modifications have been made to some programs. Specific prevention roles for parents are described in the next chapter. By incorporating or adding them to already existing programs, the programs could become even more useful.

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Chapter 3:
Alcohol and Other Drug Prevention Roles for Parents

In addition to serving their basic and more general roles as family leaders and guides and nurturers of their children's development, parents can play a variety of specialty roles in helping their children lead drug free lives. These additional roles require that parents look closely at their own alcohol and other drug use, that they become knowledgeable about an array of alcohol and other drug use issues, and, most important, that they make a drug free lifestyle for children a major childrearing goal. This requires that parents take on an additional and time-consuming responsibility and make a deep, continuous commitment to this goal. The intended result—drug free, healthy youth—is a blessing to the parents, their immediate and extended families, and the Nation.

Ten interrelated alcohol and other drug prevention roles for parents have been identified. Each role is briefly described. Then a more extended explanation of the meaning, purpose, and details of each role is offered by a nationally recognized expert in the parenting and alcohol and other drug prevention fields.

THE TEN PREVENTION ROLES FOR PARENTS

1. **Parents as role models** regarding the use of such legal substances as tobacco, caffeine, and alcohol and such illegal substances as marijuana, stimulants, sedatives, cocaine, and heroin. The focus here is on both what parents model in their own alcohol and other drug use behavior and whether and how they involve their children in this behavior.

2. **Parents as educators or information resources** for their children about: legal and illegal substances and their likely health and social consequences, family health histories regarding alcohol and other drug use, the sale of alcohol and other drugs for personal profit, and the pro-use messages that emanate from the alcohol and other drug industries, the media, and poorly informed health practitioners. This multifaceted educational role requires that parents become very knowledgeable and that their children learn to turn to them for alcohol and other drug information.

3. **Parents as family policymakers and rule setters** for their children regarding the use and sale of alcohol and other drugs. The focus is on arriving

at clear no-use and no-sale family policies or rules with clear and enforceable consequences for violators.

4. **Parents as simulators of and participants in enjoyable family activities** that provide alternatives to boredom or social events involving alcohol or other drugs. The focus is on helping children engage in healthy activities, including alcohol and other drug free parties, as an alternative to unhealthy ones.

5. **Parents as consultants and educators** of their children about peer pressure and how to resist it. The focus is on helping parents appreciate the power of peer pressure and providing children with resistance techniques.

6. **Parents as monitors** of their children's whereabouts. The emphasis is on locating children when they are not home and being reasonably assured of their safety.

7. **Parents as collaborators** with other parents in their children's world regarding alcohol and other drug use. This involves communicating about social events, monitoring children's activities, and conducting community-based alcohol and other drug prevention projects.

8. **Parents as identifiers and confronters.** This section focuses on teaching parents the signs of their children's or other children's alcohol and other drug use and how to confront children about their use of alcohol or other drugs.

9. **Parents as interveners** with alcohol- and other drug-dependent children. The focus is on how to handle children or youth who are dependent on alcohol or other drugs, and where to refer them for treatment.

10. **Parents as managers of their own feelings** about their children's alcohol or other drug use. Parents must work through these feelings so that they can take productive remedial action.

ROLE 1: PARENTS AS ROLE MODELS

Gary D. McKay, Ph.D.

Parents, teachers, athletes, music personalities, and peers all provide models for children. Parents of adolescents often exert more influence in their children's lives than they take credit for. Children are influenced most by the adults in their lives when they are very young, prior to the onset of peer influence. Parents of young children should be aware of what they model for their children (Benard et al. 1987).

If one watches young children, one observes the influence of modeling. Dan and Molly play "dress up," both imitating the behavior of their parents. Billy swears like a trooper, just like his dad. Melissa gets angry when she doesn't get her way; Mom uses anger to get Melissa to obey. Mr. Michaels gets tension headaches when he's under stress; his son Allen gets stomachaches to avoid school.

Parents often wonder why children pick up negative traits such as a "bad temper." They often do not realize that children indiscriminately imitate what they see. Parents may know that they model responsibility and other positive behaviors but be unaware that they model some negative traits as well.

MODELING ALCOHOL AND OTHER DRUG USE

Parents who drink alcoholic beverages, smoke, or drink a lot of caffeinated coffee may not think of these as drugs, nor do they always realize the influence these practices can have on their children. They may talk to their children about abstaining from smoking, for instance, but themselves continue to smoke. They may offer a child a sip of beer or wine at family parties and think there is no problem with drinking—especially if they abuse alcohol.

Most parents are unaware of the influence they exert through their use of prescription and over-the-counter drugs. Although such drugs are useful and appropriate if used properly, they can also be abused (Perkins and McMurtie-Perkins 1986). Some parents use such drugs or give them to their children without any explanation other than that the drug will make them feel better or get well.

Television not only bombards us with beer and wine advertisements, it also pushes over-the-counter drugs. These messages often go undisputed by parents. The combined message of advertising and parents' overuse of prescription and over-the-counter drugs is, "If you don't feel good, look for a drug to make you feel good." This practice might translate into using alcohol and other drugs to feel better.

McKay, Dinkmeyer, and Dinkmeyer (1989) identify the following ways in which parents can present healthy models:

- Monitoring their own use of drugs such as alcohol and prescription and over-the-counter medicines.
- Promoting health by appropriate eating and exercise habits.
- Being consistent in their attitudes about drug-influenced behavior. (Many parents become incensed about alcohol-impaired driving but laugh at drunken behavior in a television comedy skit.)
- Explaining why an over-the-counter or prescription drug is used and when it is appropriate and inappropriate to use such a drug. When a child has a headache, for example, could a warm washcloth or heating pad relieve the pain? Because many headaches are tension- and stress-related, the parent might ask the child about his or her day: did something upsetting happen?
- Discussing television commercials that advocate the use of over-the-counter drugs. Parents need to find out what the child thinks the commercial is trying to say and solicit the child's ideas about the appropriate use of medicine and the other options available for common problems such as headaches, stomachaches, and insomnia.

MODELING THE EXPRESSION OF FEELINGS

A primary purpose of alcohol or other drug use is to alter emotions. Children need to learn not to be afraid of emotions and to express them in appropriate ways. An effective way to model the expression of feelings is to use an **I message** (Gordon 1970).

An **I message** is a statement about the effects on the speaker of another person's behavior. A parent might say, "When I find mud on the rug that I have just cleaned, I feel discouraged because now it has to be cleaned again." The parent has not blamed the child but simply communicated his or her feelings about the consequences of the child's behavior. **I messages**, coupled with **reflective listening**, help children learn to express their own feelings.

In **reflective listening**, the parent demonstrates an understanding of the child's feelings and the circumstances that cause them. The parent communicates this understanding in words such as these: "You feel sad because your friend is moving"; "Sounds like you're angry because I won't let you do that." Simple ways of communicating understanding are "you feel _ because _," "sounds like you're _," and "looks like you feel _."

By using **I messages** and **reflective listening**, parents teach their children that feelings are a natural part of life and can be expressed. They also teach that expressing feelings doesn't mean losing love. A person who expresses negative feelings is nevertheless lovable.

MODELING DECISIONMAKING

Using or not using alcohol and other drugs is a decision; parents should teach decisionmaking as early as possible by allowing children to make choices consistent with their age and level of maturity. Decisionmaking begins with low-risk choices such as whether to have an egg or cereal for breakfast. Once the choice is made, the child is expected to accept the positive or negative consequences of the decision. With practice, the child learns to predict the negative consequences of decisions. This ability is especially important when deciding whether to engage in behaviors such as taking alcohol and other drugs.

Parents can also teach decisionmaking by involving the child in decisionmaking processes. Exploring alternatives is a useful model for making decisions. A parent can model the process by using the following steps to help the child solve a problem:

- Using **reflective listening** to understand and clarify the child's feelings. Problems often remain unsolved if feelings are not expressed.

- Exploring alternatives through brainstorming. To encourage creative thinking, the parent solicits all of the child's ideas without evaluating them.

- Helping the child to choose a solution. The parent asks the child to evaluate each alternative listed in the brainstorming process.

- Discussing the probable results of the decision. The parent helps the child examine the likely consequences of each decision. This is especially important when a potentially harmful behavior is being considered.

- Obtaining a commitment from the child to follow through with the chosen solution.

- Planning a time for evaluation. The solution is tested for a specific period of time—a week, for example—and then discussed ("Shall we talk about how it's going next Tuesday?").

Family meetings also provide opportunities for children to become involved in decisionmaking. Family meetings are regularly scheduled forums in which members discuss and make decisions about issues that involve the entire family. The parents model and teach group decisionmaking; everyone is held accountable for the agreements made. Agreements are in effect until the next meeting.

Parents are the primary role models of alcohol and other drug use, the expression and acceptance of feelings, and decisionmaking—areas found to be influential in a child's decision to use or abstain from using alcohol and other drugs. Parents must begin to exert their positive influence before the onset of peer pressure.

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ROLE 2: PARENTS AS EDUCATORS

Alvera Stern, Ed.D.

Parents are often the single most important influence on a child's risk of developing problems with alcohol and other drugs. Parents largely underestimate their own influence on their children. They mistakenly assume that peer pressure and other factors play a larger role than parents do. The fact is that parents are the preferred source for information on alcohol, other drugs, AIDS, and sex, and they remain so through adolescence.

Children learn through listening as well as watching, and they receive and encode important messages through both observation of and direct verbal communication from their parents. It's not just what parents do that counts, it's also what they say.

The verbal messages by which parents help to shape children's behavior in relationship to future use of alcohol and other drugs are those that convey the family's biological, medical, and health history and those that convey the health risks of using alcohol and other drugs.

The simplest messages for both parents and children to learn together are as follows:

- Drinking alcohol or using other drugs can be abusive because it can bring harm to the user or to other people.
- For children, any drinking is abuse because it can affect growth and development.
- For people under age 21, any drinking is inappropriate because it is illegal.
- For pregnant women, any drinking or other drug use is improper because it can harm the unborn baby.
- For adults using certain prescription drugs, any drinking can be abuse because it can combine in harmful ways with those drugs.
- For people with a family history of alcoholism, any drinking may be abuse.
- Engaging in sports (swimming, for example) while under the influence of alcohol or other drugs is very dangerous.
- For people who are about to drive, or are driving or operating machinery, any drinking and/or other drug use may be dangerous.
- For people whose work requires judgment, any drinking and/or other drug use can be abuse.

A family that is able to transmit this information to its younger members, by both clear verbal and nonverbal messages, has four major characteristics that set it apart from other families. First, parental messages are perceived by the youths as being meaningful to them at the time. The child internalizes these messages. Talking about drugs to an 8-year-old in a conservative midwestern suburb, for example, may have no meaning to that child. However, talking about "our family and how we (the adults) drink," or "how we don't drink," and how drinking can lead to other drug use, will have meaning to that child.

Second, the children perceive themselves as having some power in the choices to be made. Emphasis should be placed on the fact that children cannot be forced to take a drink or use other drugs. Children are taught that they can, and are expected to, say "no." Children can be responsible for their behavior, meet the expectations of the family, and achieve their ambitions.

Third, young people perceive that their alcohol and other drug free life brings rewards. These rewards can be both intrinsic (from within) and extrinsic (from without). Abstaining youths have high self-esteem, pride, a sense of accomplishment, control, and self-discipline. They begin to understand, internalize, and practice the principles of delayed gratification (the option to use alcohol will come at age 21) and "if-then" (if I avoid drugs, then I will be a more socially adept adult; if I don't drink, then I will play better in the game). The extrinsic rewards include avoiding hangovers, getting good grades, holding a good job, and being admitted to college.

Conversely, the youth who is not surrounded by a loving and supportive family, who does not have high expectations and long-term goals, may get intrinsic and extrinsic rewards from negative social behavior, including the use of alcohol and other drugs.

Fourth, young people receive constant affirmation of their work within the context of the family. The parent(s) and children spend time together confirming and evaluating themselves as a family unit and each other as individuals. They examine the work of the family unit in light of certain criteria: How are we communicating? Are our rules clear and workable? Are we on target with our goals? Are there successes we need to celebrate? Are there problems we need to work on? How can we help each other in the short term and in the long term?

Two major categories of information must be addressed, with love and understanding, in discussions between parent and child: family medical history and the effects of alcohol and other drugs on personal health and growth.

FAMILY MEDICAL HISTORY

Children who have a family history of alcoholism or other drug problems are at high risk for developing these or similar problems. Families need to communicate the family history of alcohol and other drug problems to the children, so they are aware of their own risks. Many adults do not know their own family history, and many are reluctant to drag family skeletons from the closet. It helps to realize that most families have difficulty talking about the rough times in their past. Yet most families discover that, when they do face their memories, it helps them to understand each other better.

There are some rewarding ways to help older family members open up and talk about family histories. Look at family photograph albums and scrapbooks with older relatives and ask questions about the people depicted. Create a family genealogy or "tree" and document anecdotes, professions, living conditions, socioeconomic levels, nicknames, health conditions, and reasons for death.

Let the younger members of the family make an audio or video recording of older members, asking them about their own childhood memories and what they remember hearing about their own parents' and grandparents' childhoods.

Children and adults who learn their family histories do much more than simply learn facts. They confirm their own identities and existence in the context of a family. They see their family in terms of reality and continuity.

The most important ideas to convey to an adolescent on family abuse issues can be delivered in these three messages:

- People who have a family history of alcoholism or other drug problems are at high risk of developing those or similar problems. The best choice for them is not to drink or use other drugs, ever.
- The earlier a person starts drinking, the shorter the time it takes to become addicted to that drug.
- If a person drinks or uses other drugs and starts getting into trouble, help is available. The family needs to know where to go to get that help. This behavior could be a medical problem for which there is medical treatment, in addition to other forms treatment.

EFFECTS OF ALCOHOL AND OTHER DRUGS ON PERSONAL HEALTH AND GROWTH

Young people need to learn from their parents that alcohol and other drugs can harm the body. Even a student in the lower grades of elementary school can understand two critical concepts. First, the smaller (younger) and less physically developed a person is, the more damage alcohol does to the body. When children or teenagers drink, because they are younger and smaller physically and their body, metabolism, brain, and sexual systems are still being developed, these systems will be affected much more, and more quickly, than those of a mature adult.

Second, the more alcohol a person drinks, the more damage alcohol does to the body. For example, 1 drink may make a young person feel warm, 4 drinks may make a young person intoxicated, and 12 drinks may be fatal. Even for adults who are not in high-risk categories, the U.S. Surgeon General recommends no more than two drinks a day, ever. The safest choice for adults is to abstain, and many do.

The health facts that parents can give to their children can be divided into four main topics: effects on sexual hormones and sexuality; effects on the mind and the brain and, therefore, on behavior; effects on other body systems, such as the cardiovascular system and liver; and the relationships among alcohol, other drugs, sex, and AIDS.

Effects on Sexual Hormones and Sexuality

By the time a child enters sixth grade, it is appropriate for parents to talk about how alcohol affects sexual behavior, as part of a discussion of sex. The parent can explain that alcohol affects not only the sexual hormone levels of the body but also the way people behave sexually.

In males, alcohol decreases the level of the chief male hormone, testosterone, and increases the level of the chief female hormone, estrogen. This effect has been observed within hours of drinking and continues through to a hangover state.

For men who are chronic heavy drinkers or alcoholics, reduced levels of testosterone and increased levels of estrogen may lead to reduced sexual drive, lower sperm count, higher incidence of sperm abnormalities, feminine pubic hair distribution patterns, development of breasts and other feminine weight distribution patterns, infertility, or impotence.

For females, the effects of alcohol on the hormonal system include a decrease in production of the chief female hormone, estrogen, and an increase in production of the chief male hormone, testosterone. For the chronic heavy drinker, this change in hormone levels leads to the loss of female secondary sexual characteristics such as heavy fat deposits in the breasts and hips, reduction or cessation of the menstrual cycle, production of fewer ova, and eventual infertility.

This basic information can be explained in simple terms by a parent to an adolescent in a very loving and nonjudgmental way. The essential message can be, "We love you. You are growing up to be a fine young person. We want you to be healthy and strong. We also know that you will be seeing some of your friends mess up their lives by drinking alcohol and using other drugs. Drinking alcohol, including beer, is not 'cool.' It can harm or destroy your health."

A child in sixth or seventh grade should be told, "Some children in your school are starting to use alcohol or other drugs. This behavior is unacceptable to our family because we want to stay healthy, we have plans and goals and expectations for each other, and it does not fit in with our (religious, cultural, family, or traditional) values. But we must realize that those children who do start using alcohol and other drugs don't understand how it affects their brains and bodies."

The child should be told that drinking is seen by some children as an adult act, so drinking children may start hanging around older kids. Because drinking children see themselves as engaging in one adult behavior, they may start to experiment with other adult activities.

Alcohol is a neurotoxin, and it interferes with the way we think and make decisions. Therefore, when young people drink, they are more likely to do things they would not normally do. The use of alcohol and other drugs is very often associated with inappropriate sexual behavior, including practicing sex with multiple partners, committing sexual violence such as date rape, sexual abuse, and incest, and committing other forms of domestic violence.

Here again, this information must be given in a very loving and caring way that reassures the young person (see examples of parent/child dialog in Role 3). These messages can be conveyed in the context of an explanation of family values concerning sex and the importance of respecting and treasuring the differences between men and women.

Effects on the Mind, Brain, and Behavior

The message parents can give to the elementary school child about the effects of alcohol and other mind-altering drugs is something like this: "Our brain works like the biggest, most powerful computer ever imagined, but it's even more complex than that. Just as we have to keep dust and smoke and cat hairs and spilled milk and cookie crumbs from a computer, we have to keep foreign pollutants from our brains. Alcohol and other drugs are called neurotoxins; they act as poisons to the brain. They affect our brain chemistry, which is responsible for our behavior. If we change our brain chemistry by the use of alcohol and other drugs, we will affect the way we act, and that may cause harm to ourselves and other people."

The adolescent who has heard and talked about this information for several years will be ready, willing, and eager to find out more about the working of the brain. For example, a fun activity for family members is to compare how different individuals in a family think—one child may have thought patterns very similar to a parent's or grandparent's, whereas another may think more like an aunt.

When the child has reached this analytical stage of thinking, usually around puberty, the parent can talk about four effects of alcohol and other mind-altering drugs on the brain: (1) increase in reaction time, (2) loss of memory and ability to store new information in memory, (3) failure to develop analytical skills, and (4) addiction.

Increase in reaction time. The brain works via complex firing sequences of electrical impulses through a complex network of neurons. These neurons work like electrical cords. As long as the cords are unfrayed and plugged in tight, and as long as all the plugs are clean and working, the message goes through easily and quickly. If the person is drinking or using other drugs, chemical reactions from the alcohol or other drug will affect the chemicals required to make the message flow through the cord (neuron) and the plugs (neurotransmitter sites). This causes the message to be slowed down, and the drug user cannot fire the message fast enough to think clearly. For example, if a man who has had several drinks tries to walk across an intersection, his ability to react to oncoming traffic will be severely hindered.

This increase in reaction time occurs in females weighing 120 lbs. with consumption of fewer than two beers and in males of 180 lbs. with consumption of fewer than three beers. Young people need to know that a very small amount of alcohol can affect their thinking and make their reaction time longer.

Loss of memory and ability to store new information in memory. A more complicated function of the brain is to record facts for later use. Considerable energy is required to record data. The chemicals must be pure. If artificial chemicals such as alcohol or other drugs come into the brain the message may be recorded selectively, inaccurately, or not at all.

When a person has been drinking or using other drugs, the brain finds it difficult to sort through the masses of data and pull out the information required. Thus, judgment is slowed and impaired.

Critical to the adolescent thinker is the fact that much learning takes place by trial and error. People learn from their past mistakes and successes, from watching other people and events, from experiencing, practicing, acting out, studying, communicating, and socializing. A person under the influence of alcohol or other drugs fails to put into memory those things that happen while using the drug.

The most severe manifestation of this memory loss is called a blackout. In that state, people may be awake and go through all the appropriate actions of carrying out a routine task, but be unable to remember what they did.

Failure to develop analytical skills. Young people need to know that they are particularly vulnerable during adolescence and early adulthood to the effects of alcohol and other mind-altering drugs. The teen years are marked by functional and structural changes in the brain. The development of analytical skills is absolutely necessary if the young person is to become a mature, responsible, thinking adult. This analytical thinking is the highest level of mental activity and requires the most electrical and chemical energy. Neurotoxins, described above as hindering reaction time, also impair analytical thought.

Addiction. The most serious result of alcohol and other mind-altering drugs on the mind may be chemical dependency, or addiction. In a certain percentage of cases, as a person drinks or uses other drugs, the chemical derivatives from the drugs affect specific neurons in the brain that have endings called opiate receptors. These opiate receptors "crave" neurotransmitters to fill their opiate receptor sites. In most people, the opiate receptor sites are filled with endorphins, which are natural opiate-like chemicals produced by the body.

However, sometimes the body produces fewer endorphins than are needed to fill these sites. The opiate receptor sites seek out a substitute. Unfortunately, a class of chemicals—the mind-altering chemicals such as alcohol and other drugs—create look-alikes that almost fit the bill. The opiate receptors are satisfied with the artificial look-alikes until their effect wears away in a few hours. Then the opiate receptors demand to be filled again. This chemical demand is interpreted by the drug user, through learned behavior, as a craving for another drink or more of another drug. As more and more alcohol is drunk, or more of another drug is taken, more and more artificial look-alikes fill the opiate receptor site. The neuron therefore produces less and less natural opiate or endorphin. This process eventually sets up a vicious chemical reaction at the neuron level in which the opiate receptor site craves to be filled, the person drinks or uses another drug, the site is filled, the look-alike effect wears off, and the opiate receptor site craves. At this stage, the person exhibits the behavioral expression of chemical addiction: using alcohol or other drugs to feel "normal."

The adolescent needs to receive the above information from a parent in the context of a discussion of family values. By the time children are in ninth grade, they are well aware of all of the behaviors mentioned above. In all likelihood, the adolescent has friends or classmates who drink, get drunk, use other drugs, become violent or abusive, and "forget" and have blackouts. They may not know the proper words, but as a parent and young person talk together about these issues, the teenager will start to remember and analyze what has been seen and heard.

In a very loving and nonjudgmental way, the parent can state that, if the teenager has a friend in trouble with alcohol or other drugs, the teenager may want to take the following actions:

- Find out where to get help for the friend.

- Look up such groups as ALATEEN or ALANON.

- Contact the school student assistance program, Peer Helpers, Natural Helpers, REACH, or whatever group the school has to help chemically dependent students.
- Learn more about chemical dependency and talk to the friend aout the help available to children in the school.
- Stop hanging around with a friend who refuses to accept help.

If for some reason no help is available for the student, parents and friends together should contact the administrators of the school and insist on adequate resources for school prevention, intervention, and treatment services.

Effects on Other Body Systems

The parent can state the basic fact that alcohol abuse is one of the leading health problems in the United States because of its impact on a person's general physical health. Alcohol decreases the number of white blood cells; weakens the body's immune system; damages the liver, which may interfere with the body's ability to fight off disease; depletes the body of vitamins and minerals essential for growth and health; and lowers hormone levels (hormones may protect against diseases such as breast cancer in women and heart attack in men).

It is important to talk to the adolescent about the fact that moderate (one 1-ounce drink per day) drinking *may* reduce the incidence of heart attack in older males. The young person needs to be told again that occasional drinking for adults of legal age, ***not in high-risk categories***, may not be considered harmful. The parent should make sure the young person understands that for the high-risk adult, any drinking is abuse. For example, women who are pregnant, adults under medication, recovering alcoholics, or those from a family with a severe history of alcoholism should not be drinking.

Relationship Among Alcohol, Other Drugs, Sex, and the Human Immunodeficiency Virus (HIV)

In their periodic conversations on the issue of alcohol and other drugs, parents need to make clear to their children that anyone using alcohol or other drugs may be at high risk for contracting HIV for three main reasons:

- Alcohol and other drugs may damage the body's immune system, leaving the body in a weakened state when trying to fight off infections, including HIV infection.
- Alcohol and other drugs may alter decisionmaking and risk perception and otherwise impair judgment. Thus, people using alcohol or other drugs may engage in high-risk sexual activities that they would avoid if not under the influence of that drug.

- HIV is currently being spread fastest among intravenous drug users and their sex partners. Alcohol is considered a "gateway" drug, which means that intravenous drug use is generally preceded by use of alcohol. Although most youth who use alcohol do not go on to use heroin or other injectable drugs, those who start using alcohol or other drugs at an early age may be at higher risk for exposure to HIV through unprotected sexual behaviors or contaminated injection equipment.

Responsible, clear verbal communication from parents can affect children's knowledge about and attitudes toward alcohol and other drugs.

ROLE 3: PARENTS AS FAMILY POLICYMAKERS AND RULE SETTERS

Michael H. Popkin, Ph.D.

One of the most important lessons that parents must teach their children is the critical relationship between freedom and responsibility. We are grateful to live in a democracy, and proudly proclaim the advantages of life in a free society. But even in the United States, freedom has its limits.

We are a society of laws—laws that both protect our freedom and limit it. As long as we handle our freedom responsibly, we may pursue happiness as we choose. However, should we freely choose to break the law, society judges us to have behaved irresponsibly, and we must suffer the consequences. In other words, if we stay within the limits of the law, we stay free; if we break those limits, we can lose some of our freedom.

It is important to parent children in a manner consistent with the type of society in which we live. Teaching children how to use their freedom responsibly is critical, especially in the area of alcohol and other drug use.

Laws prohibit the possession and use of certain drugs such as marijuana, cocaine, and heroin. Laws also state that other drugs such as alcohol may be used by adults, but not by children or teenagers. The laws are very clear, though the consequences for breaking them are often less so. Abuse of legal drugs such as alcohol and tobacco is the major drug problem in America.

The laws in families are called rules. For rules to be effective, children and teenagers need to know three things: exactly what the rule is, exactly what the parent expects, and exactly what the consequences will be if the rule is broken. In some situations, it may be advisable to involve a teenager in developing rules and consequences.

EXACTLY WHAT IS THE RULE?

Parents have a lot of freedom in setting the rules for raising children. If teaching our daughter to put away her own toys is important to my wife and me, we are free to make the rule that toys must be put away before dinner is served. The consequence for not putting the toys away might then be delayed dinner or, perhaps, losing the freedom to play with those toys for a day.

However, this freedom to set household rules has limits. Because the law governs alcohol and other drug use, it is our job as responsible parents, as well as responsible citizens, to inform our children of the law. In other words, we may not institute household rules that conflict with the law.

Thus, the rule in responsible, law-abiding families is: "No use of any illegal drugs by anyone, and no use of alcohol by anyone under the legal drinking age."

EXACTLY WHAT DOES THE PARENT EXPECT?

Clearly stating the no-use rule is an important first step. The next step is even more important and more difficult. Because many parents grew up believing that "rules were made to be broken" and that "all children experiment with alcohol and other drugs," they give a hidden message that sabotages their own no-use rule. Even as they state the rule, their children see that "they don't really expect us to keep this rule."

Parents, especially those of us who came of age during the drug-using 1960s and 1970s, must accept the ideas that (1) it is best for our children to wait until they are of legal age before they decide whether to use alcohol and (2) they should not use illegal drugs. Life is complex enough without mind-altering drugs and illegal activity.

Once we acknowledge that these are the best choices, it is extremely important to communicate to our children that we expect them to abide by the no-use rule completely. This is not said in a threatening or angry manner; we want to be firm, yet caring. In fact, we should acknowledge that it may be difficult at times for our children to comply with the rule. They can expect peer pressure and curiosity to lead them to consider breaking the rule. We can show confidence, however, that they have the courage and wisdom to withstand the pressure and resist the temptation.

EXACTLY WHAT ARE THE CONSEQUENCES?

The importance of consequences in teaching responsibility to children is so great that some program developers have said, responsibility equals choice plus consequence." Consequences usually work best when the child or teen knows what the consequences will be before the misbehavior occurs. However, in the case of the no-use rule, focusing too much attention on consequences can be counterproductive for two reasons: Teenagers might infer that we expect them to test the rule, and specific consequences lead some teens to wonder whether the thrill of using is worth the consequence. For these reasons, when no alcohol or other drug use is expected, I suggest that consequences be discussed in more general terms.

For example, a parent might say:

"Let's be clear about something. For us to continue to feel good about giving you more freedom and more responsibility, we have to be able to trust you. This no-use rule is largely a matter of trust. We won't be there looking over your shoulder every minute, nor do we feel the need to keep you locked up in the house during all your free time. But if you should break that trust, the responsible thing for us to do as your parents would be to keep a closer eye on you. That means keeping you home more often, checking up on you more regularly, and otherwise cutting down on your freedom. And, because drinking is illegal for you and driving while intoxicated can be deadly, we'd want to protect you from using the car."

If a teen already has a history of alcohol or other drug use, or breaks the no-use rule, the consequences can be more specific. Rather than rely on the common and often ineffectual consequence of "grounding," it is better to withhold privileges, possessions, and favors that the teen wants.

One word of caution: It is important that these consequences be logically connected to the broken no-use rule, and that the connection be explained to the youth. The loss of car privileges is logically connected to the use of alcohol and other drugs because of the safety factor. Not being allowed to go to concerts or parties for a period of time is logical in that these are trust situations and the teen has temporarily lost the parent's trust. By talking with a spouse or other adults, a parent can come up with a list of consequences that will be meaningful to a teen.

DISCUSSION OF NO DRUG USE

Ideally, discussions about alcohol and other drugs should begin when a child is very young. A 5-year-old is not too young to begin understanding that drinking is something that adults may do if they choose, but it is not for children. The child can also be told that there are good medications (such as those the doctor prescribes when the child is sick) and bad drugs (those that someone other than Mommy or Daddy gives). As the child gets older, more specific information should be given and a deeper understanding of the risks and reasons for prevention established. The key is to talk about the topic often, in small doses, and at a level consistent with the child's age.

The no-use rule can be part of these discussions from the beginning. With young children, the parent can simply say, "Alcohol isn't for children and bad drugs aren't for anyone." As the child gets older, the rule can be stated more explicitly: "The rule in our family is no use of illegal drugs by anyone and use of alcohol by adults only." (A parent may want to add cigarettes to the adult-choice side of the rule.)

It is a good idea to call a family meeting to discuss the use of alcohol and other drugs. But before calling such a meeting, a parent should do some homework to find out *why* alcohol and other drugs are illegal for children, teens, and adults under age 21 (this manual will help). A parent should be familiar with some statistics, have some knowledge of important medical findings regarding effects of alcohol and other drug use, and know what the legal penalties are. Your teens will ask. If a parent cannot back up the rule with some logical information, the risk that the rule will be broken is increased.

The days of teenagers doing what we tell them "because we're their parents and we said so" are over. Today's teenagers will challenge, question, and debate more strongly than ever before. The wise parent will allow open discussion, provide solid information, and yet remain firm in establishing and enforcing a no-use rule.

ROLE 4: PARENTS AS ORIGINATORS OF AND PARTICIPANTS IN HEALTHY FAMILY ACTIVITIES

J. David Hawkins, Ph.D.
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Teenage rebelliousness—it is almost a cliche. Yet teenagers who become alienated and rebellious and are not bonded to family and school are particularly at risk for alcohol and other drug problems (Hawkins et al. 1986, 1987). Why are some teenagers so alienated, so turned off from their families, their schools, and the positive side of life? The answers are complex and vary by individual. Part of the answer lies in the nature of American adolescence.

In America today, the teenage years are a time of limbo. No longer children and not yet adults, teenagers begin to explore their identities. We expect these explorations to be limited: teenagers are not expected to become parents or major contributors to the economy before leaving school. Though their bodies may be ready for these roles, they live in a society that requires greater preparation for true adulthood. Children in middle and high school grades are still expected to be learners.

Much of their time is spent in school and on homework, preparing for a future that can seem distant. For those young people who need more immediate gratification, it is sometimes hard to see the connection between the seemingly interminable years of schooling and ultimate success in the "real world."

This is particularly true for young people who do not excel in school or other activities. Children who fail academically and who do not receive recognition or rewards for participation on teams or in other school activities often feel alienated. Feelings of alienation are accompanied by rebelliousness, rejection of conventional avenues to adulthood, and an exploration of alternative paths to personal identity, reward, and pleasure. This rebellious exploration increases young peoples' risk of developing problems with alcohol and other drugs.

As they enter their teen years, children's experiences in the family can contribute to or protect them from social alienation. When teenagers have no responsibilities in the family, they remain dependent, child-like beneficiaries of their parents. When their responsibilities are limited to the routine chores they have had since childhood, they may see the tasks as childish and boring. These tasks can become a source of family conflict and teenage rebellion.

As children become teenagers, parents should consider new ways to involve them in the family. At this time, they naturally seek to take more control of

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Note: The material in this section was adapted from *Preparing for the Drug (Free) Years: A Prevention Program for Parents.* Seattle, WA: Developmental Research and Programs, 1988.

their own lives, to become more independent. Parents can help adolescents achieve independence and, at the same time, prevent the process of escalating alienation and rebelliousness by exploring new responsibilities within the family that will prepare their children for adult life.

By providing challenging, developmentally appropriate responsibilities within the family, teaching them the skills they need to meet these new challenges, and recognizing their efforts, parents can help teenagers master the skills they will need as adults. When teenagers find themselves making essential contributions to the family, see that they are responsible for important adult-like family functions, and find themselves developing new skills, they are unlikely to become alienated from the family and rebellious.

By increasing family involvement in these ways, parents can prevent alienation, which is a major risk factor for teenage alcohol and other drug use. Parents should examine the following four areas of family life in which to involve their teenage children.

FAMILY GOVERNANCE

If parents make all of the family rules and decisions without the input or involvement of their children, they lose an opportunity to teach teenagers the basic skills of decisionmaking: how to generate alternatives, consider options, evaluate the likely consequences of actions, and make wise choices. Children can learn to make good decisions by actively participating in family decisionmaking. Children who have learned how to make good decisions by thoughtfully considering the consequences of their actions are better prepared for adult independence and are less likely to use alcohol and other drugs.

Consider the diversity of the rules and decisions that affect family life. What time the children have to go to bed, who stays to babysit, where the family goes on vacation, and what to watch on television are just a few examples of family decisions in which young people can participate. Depending on their ages, the specific issue, and the family's cultural traditions, children may act as consultants or advisors on some family decisions, have a vote in others, and even have final say on certain issues in some families. By participating in family decisionmaking, children not only learn skills, but are also given a chance to practice making decisions under the watchful eyes of their parents, where mistakes can be corrected quickly.

Regardless of family composition or parenting style, involvement in family decisions gives teenagers a greater sense of control over their lives. In some families this may mean that parents are the final decisionmakers but children are consulted for input. In other families, children may have a vote on certain issues such as where to go on the family vacation. In still other families, children may be given the decisionmaking authority over such issues as how to spend their yearly clothing allowance. However children are involved in decisionmaking, it gives parents an opportunity to evaluate the suggestions and decisions their children make and to determine how much responsibility each child is ready to assume.

MAINTENANCE

In order to keep a family going, a wide variety of tasks must be completed on a regular basis: cleaning the house, taking care of the car, doing the laundry, and repairing broken appliances. Usually children are responsible for completing one or more of these tasks. Often they are assigned the routine, mundane jobs, and often they complain about and neglect their chores. Taking out the garbage year after year is far from challenging, and it certainly is not adequate preparation for adulthood.

If children are to become effective adults, they must learn the whole spectrum of family responsibilities. An ideal time to expand their participation in household tasks is when they enter their teens. They are eager to be treated "like grown-ups" and may want to assume responsibility for adult jobs such as changing the oil in the car, shopping for groceries, rebuilding the lawnmower, doing the family laundry, or preparing meals.

Young people are more likely to complete their chores if they have some voice in choosing them. Parents should assign, or encourage their children to consider taking on, tasks that are both challenging and appropriate for their ages. By taking time to teach children how to meet their new responsibilities, parents help to ensure that the job will be done according to family standards. When their parents take the time to teach them new skills and recognize their hard work, teenagers feel proud and competent, willing to take on new challenges.

FINANCE

Managing money is a major adult responsibility. The first checking account, credit card, or loan brings responsibilities that are both challenging and frightening. Too often, young people find themselves in debt and humiliated shortly after leaving home. Too often, parents find themselves paying off their children's bills. Parents can avoid such heartaches by teaching their children the skills of managing money and encouraging them to practice these skills in an environment where mistakes are not too costly.

As children enter adolescence, they can learn to manage money in several ways. They can comparison shop to find the best buys, help to pay bills, take responsibility for the money allotted for their new school clothes, help their parents balance the checkbook, save money to pay part of the cost of an expensive item, or open a checking account. Taking responsibility for budgeting, paying bills, and making purchases helps teens learn important skills that they will use for a lifetime.

HEALTH

In recent decades, Americans have become more health conscious. Many people have struggled to change their lifestyles by limiting their intake of sugar and fat, getting more exercise, and quitting smoking. But changing unhealthy habits is difficult; relapse is a common problem. It is much easier to establish and maintain healthy habits.

Parents can teach their children the skills they need to keep themselves healthy. As they enter adolescence, young people can take responsibility for a variety of health tasks such as getting dental checkups, establishing a personal or family exercise plan, making their own doctor appointments, or planning menus that include the four food groups. By maintaining good health, children enhance the quality of their lives and avoid having to change bad habits.

Expanding children's roles in the family involves more than simply handing children new responsibilities. The change is most likely to be successful when three principles are followed:

- Increase children's **opportunities** to contribute actively to the quality of family life by engaging them in developmentally appropriate, ever-increasing, and significant family roles.
- Teach children the **skills** they need to make an effective contribution to the family.
- Recognize, support, or **reward** children for contributing and making a sincere effort. Provide corrective feedback when performance does not meet family standards.

Expanding children's roles in these ways can prevent the development of alienation and rebelliousness and strengthen family bonds. When teenagers maintain strong bonds to their families, they are less likely to use alcohol or other drugs and associate with people who could get them in trouble. Positive involvement with the family can provide a positive alternative to alcohol and other drug use.

Parents can also take an active role in encouraging their children to become involved with community and school groups. Parents should guide their children's choice of activities according to the children's interests and abilities. An activity should:

- provide an opportunity for interaction with other young people who have decided to be alcohol and other drug free,
- provide the young person with an opportunity to make a significant contribution to the group,

- be appropriate given the skills and time the young person has available, and
- include adequate adult supervision, support, and reinforcement.

This section has considered ways parents can increase their children's positive involvements and decrease rebelliousness and alienation during adolescence. It is important to note one kind of teenage involvement that does not appear likely to reduce the risk of alcohol and other drug use. Participation in unskilled, low-paying afterschool or weekend jobs during the high school years does not appear to reduce children's risk of developing alcohol and other drug problems (Steinberg et al. 1982). Although many teenagers must take on such jobs for personal and family economic reasons, there are indications that working during the high school years may lead to more frequent school absences, decreased enjoyment of school, and lower school grades. Working at a job during the high school years may inhibit participation in important roles in school and the family that are developmentally appropriate for teenagers in American society.

Involving children in important family, school, and community roles reduces boredom and alienation while increasing children's sense of personal effectiveness. Children who know they are significant contributors to their families, schools, and communities are less likely to use alcohol and other drugs. Parents can enhance their children's development and reduce their risk of alcohol and other drug use by expanding their children's family roles and encouraging them to join school, community, and peer activities that oppose alcohol and other drug use and teach young people the skills they need to be productive adults.

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ROLE 5: PARENTS AS CONSULTANTS AND EDUCATORS ON PEER PRESSURE

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Parents who want to prevent their children from using alcohol and other drugs must move beyond the basics of good parenting. In addition to obtaining information from a physician regarding the medical effects of alcohol and other drugs, they must consider the specific factors that put their children at risk for alcohol and other drug problems and do all they can to reduce these factors in ways that encourage their children's healthy physical, cognitive, social, and spiritual development.

Many parents believe that their influence automatically decreases when children reach adolescence. They have been told that it is normal for adolescents to replace parental influence with peer influence. This is not necessarily the case. Research indicates that children prefer to learn about a variety of important topics from their parents rather than from their friends (Dickinson 1978). Peer influence increases during adolescence, but the influence of parents on their children can remain strong if positive family bonds have been established before children enter their teen years.

Parents can be an especially important preventive force when their children face peer influences to use alcohol and other drugs. A recent survey of students in King County, Washington, revealed that 36 percent of 5th grade students, 54 percent of 8th grade students, and 79 percent of 10th grade students had already refused an offer of alcohol or other drugs. At all three grade levels, students mentioned their parents most often as the single most important reason for refusing alcohol or other drugs (Catalano et al. 1987).

Establishing a clear family position on alcohol and other drugs provides children with the motivation to refuse alcohol and other drug offers (Hawkins et al. 1988). However, establishing a family position is not enough to ensure that children will remain drug free. Children need skills to be able to resist both subtle and direct social influences from their peers. These skills have been called resistance skills.

A number of school programs have been developed to teach resistance skills to fifth through ninth grade students. Teaching resistance skills in the classroom has been shown to delay first use of cigarettes, alcohol, and marijuana. Studies have shown that training in resistance skills is most effective when the skills are reviewed and practiced repeatedly. Although practical resistance skills are helpful, they alone are not enough to help a young person avoid alcohol and other drug use.

For this reason, even in areas where schools teach resistance skills, parents can take action to ensure that their children can actually use resistance skills when they need them. When parents practice resistance skills with their children, they demonstrate their commitment to drug free adolescence. Parents can also practice these skills during time spent with their adolescents, such as trips in the car, visits to shopping malls, and time spent together at home. Practicing in the children's normal environment enhances the probability of their using resistance skills.

Below are some important things parents can do to help their children recognize and resist peer influences to use alcohol and other drugs.

Provide Your Children With Accurate Information on the Extent of Use by Their Peers

Teenagers in middle and junior high school often have inflated views of the extent of alcohol and other drug use by their peers. They erroneously believe that they are in a small minority who do not use alcohol and other drugs. Parents can counter this perception and the indirect pressure that accompanies it by gathering and sharing with their children accurate information on the extent of alcohol and other drug use by children their age. At the national level, this information is available in the results of annual surveys of high school seniors released by the National Institute on Drug Abuse.

Increasingly, States, county agencies, and schools are gathering statistics to provide a more accurate picture of alcohol and other drug use by teenagers in their jurisdictions. By calling their State or county drug abuse prevention office or their local school district office, parents can obtain information on the extent of alcohol and other drug use by youth in their area.

Teach Your Child Resistance Skills Early

Research indicates that children are at greatest risk of beginning to use alcohol and marijuana before the age of 15. If they are to avoid early use of alcohol and other drugs—an important risk factor for alcohol and other drug problems—children need to learn resistance skills as early as possible, preferably before age 9 and no later than age 12. Fortunately, many children at these ages are opposed to drug use and are receptive to their parents' efforts to teach them skills that reinforce their current attitudes.

Be Clear About the Nature of Peer Influence

Most children are first offered alcohol and other drugs by a friend or sibling, not by a stranger. Yet many teenagers report that their friends do not pressure them to use alcohol and other drugs. The influence to use is often subtle and indirect; it may not take the form of overt pressure.

Imagine a teenage boy going to the movies with his friends. Someone takes out a bottle and passes it around. Everyone else is drinking. Even if no word is spoken, the feeling of pressure mounts as the bottle gets closer. The teenager may not want to drink, but he does not want to be embarrassed or left out either. It will be difficult for him to avoid drinking unless he knows how to do it in a way that will not make him feel foolish. Even when no one is pressuring, it can be difficult to resist going along with the crowd. Both parents and teenagers should recognize that skills are needed to resist the frequently subtle influences to use alcohol and other drugs as well as the less frequent pressure to use.

Evaluate Alternative Resistance Skill Approaches

A number of approaches to resisting peer influences have been developed. Parents should use the following criteria in deciding which approach to teach their children:

- The skill should be simple and provide children with the exact phrases to use to turn down an offer. Children will not use resistance skills if they have to stop and think through complicated steps.

- The skill should empower children to look good, have fun, and keep their friends while staying out of trouble with alcohol and other drugs. Many children want to stay out of trouble, but may be afraid to say no because they do not want to look stupid. Children will be willing to use resistance skills only if they think they can say no and still keep their friends. They are more likely to use skills that enable them to have a good time while saying no to alcohol and other drug use.

- When resistance skills are part of the school curriculum, the skill taught by parents should use the same steps as those taught at school, to avoid confusing the child.

Practice Resistance Skills With Your Child

Once parents have selected a resistance skill approach, they should practice the skills frequently with their children. Initially the practice situations should be fairly simple to ensure that children's first experiences are positive and successful. After children have learned the skills, parents can experiment with applying pressure.

Learning resistance skills is similar to learning to ride a bike. Everyone makes mistakes at first but, with guidance and practice, everyone improves. No one learns to ride a bike by discussing how to do it; children will not learn resistance skills by talking about them. Only through practicing in many different situations will children become comfortable enough to use the skills when they need them.

Parents should make practice sessions fun. Many children enjoy role playing, especially when parents and children take turns playing the troublemaker and the skill user. Below are examples of role playing to practice. The following 5-step Refusal Skills® Model was developed by Roberts, Fitzmahan, and Associates and Elliot Herman. Refusal Skills® is part of the substance abuse prevention curriculum Here's Looking at You, 2000,® distributed by the Comprehensive Health Education Foundation (CHEF®).*

Ask questions

Troublemaker: "Let's go over to my house after school."

Skill user: "What are we going to do?"

Troublemaker: "Well, my parents are away."

Skill user: "So?"

Troublemaker: "I thought we'd try a couple of beers."

Asking questions gives the skill user the information needed to avoid trouble. Children can stop asking questions as soon as they know exactly what they are being asked to do.

Name the trouble

Skill user: "That's illegal. It's 'Minor in Possession.' Besides, it's against my family's rules."

Naming the trouble identifies the problem with the suggested activity from the skill user's point of view. Using the legal name for the violation emphasizes its undesirability.

Identify the consequences

Skill user: "If I did that I could be arrested. My parents would place me on restriction. Then I wouldn't be able to have any friends over, watch television, or even talk on the phone."

Naming the consequences provides the skill user's reason for staying out of trouble.

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*Note: The Refusal Skills® trademark is owned by, and the 5-Step Refusal Skills Model is copyrighted by Roberts, Fitzmahan, and Associates and Elliot Herman. Permission to include the 5-Step Refusal Skills Model was granted by the by the Comprehensive Health Education Foundation (CHEF®). All rights reserved.

Suggest an alternative

Skill user: "Why don't we go down to the basketball court and shoot some baskets instead?"

By suggesting an alternative, skill users communicate to their friends that they are saying no to trouble but not to the friendship. They also present a different, more positive way to have fun together that avoids trouble and puts the skill user in a leadership role.

Move it, sell it, and leave the door open

Troublemaker: "No, I don't think so. That sounds pretty boring to me."

Skill user (moving away from friend): "If you change your mind, I'll be at the court until 5:30. I'll bet you an ice cream that you can't beat me one-on-one."

Even if the friend does not accept the alternative, the skill user stays in control by leaving the situation and saves face by leaving the door open to the friend to join in a positive activity.

Parents and Peers—Your folks are your friends, too

Associating with alcohol- and other drug-using peers is a major risk factor for teenage alcohol and other drug use. Parents should counsel their children to cultivate new friendships. By teaching their children to recognize and resist peer influences to use, parents can take an important step in reducing the risk that their children will use alcohol and other drugs. Losing a friend is sad, but the alternative risk is too great.

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ROLE 6: PARENTS AS MONITORS AND SUPERVISORS

Patricia Chamberlain, Ph.D.

Well-supervised children and teenagers simply do not have as much opportunity to use alcohol and other drugs as their less supervised counterparts. Common sense would dictate that teenagers who have a great deal of unsupervised time are at risk of drifting into a deviant peer group. As might be expected, prolonged contact with peers who have alcohol and other drug problems increases the probability of developing these problems. Unfortunately, as children get older, the definition of appropriate and adequate supervision becomes more complex. This is compounded by the fact that, in most families, parents work and have less time to supervise their children.

Any American teenager will be glad to tell you, "I need my freedom." Adolescence brings with it the task of gradually developing the skills needed for independence from the family. With the increased right to and need for freedom comes increased responsibility for both the parents and the adolescent. For parents, knowing where their son or daughter is going, and with whom, takes work. For the adolescent, the object is to demonstrate the ability to handle increasing amounts of freedom.

This section recommends methods for teaching a child to assume increasing amounts of responsibility for planning activities, being on time, and checking in. Some aspects of this parental role are similar to Role 3, Parents as Family Policymakers and Rule Setters. The development of household rules for unsupervised time and a system of supervision for teenagers whose parents work outside the home are illustrated.

SETTING UP THE RATIONALE FOR SUPERVISION

Before beginning to teach a child to earn more freedom from direct supervision, it is often helpful to discuss, in a general way, the parent's rationale for supervision. This should be done briefly, without lecturing or criticizing the teenager. An example of a dialog between a mother and her 14-year-old son follows.

Mother: "Now that you are starting high school you will have more opportunities to do things on your own and with your friends. Dad and I want you to have these experiences, but we also have to feel okay about knowing where you are and whom you're with. It's our job as your parents to keep track of you."

Son: "I know that. What are you planning to do, follow me around?"

Mother: "We hope that won't be necessary. What I want to do is to come up with a set of house rules about what time we expect you to be home after school and on weekends. Once we agree on the times, you can let us know what your plans are—where you will be and whom you will be with—and if they are okay with us, we're all set. As you show us that you can be where you say you'll be and come home on time, we will feel comfortable letting you do more and more things. Let's begin by having a meeting about the house rules. How about tomorrow after dinner?"

Son: "Okay. How long will it take?"

In this conversation the mother makes the following points:

- The child will be getting more freedom from now on.
- The parents will insist on knowing where the child is and whom he is with.
- House rules will be established about check-in times and curfew.
- As the child demonstrates responsibility, more freedom will follow.

ESTABLISHING AND MONITORING HOUSE RULES

The next step is to establish your own set of house rules about supervision. When do you expect your child to be home after school? What time is curfew on weekend nights? Is the youth allowed to go out on school nights? If so, how many per week, and when is curfew? In two-parent families, these should be discussed and agreed upon by both parents. Teenagers commonly defeat parents' supervisory efforts by finding an area of disagreement between the parents and playing one parent's point of view against the other. In single-parent homes, it is often helpful to discuss your proposed house rules with the parent of a child near in age to yours.

A recent survey of fourth grade boys found that, on the average, they had 45 minutes of unsupervised time per night during the school year. The figure was 1 hour for 7th graders and 2 hours for 10th graders. It is reasonable for parent(s) to know the whereabouts and companions of a child of any age, and this information is essential for working parents of teenagers.

It is helpful to write down the rules you and your children decide upon. The rules should be stated briefly, as in figure 1.

This kind of form allows parents to keep daily track of the child's observance of house rules. (The rules, of course, will vary with the family circumstances and age of the child.) The parent enters a yes or no after each house rule for each day of the week. Next, to help teach children to become increasingly responsible and independent, parents should systematically reward children for their efforts and identify the consequences of failing to follow the rules.

Figure 1: Sample tracking form for monitoring house rules

House rules for week of ____________________

	MON	TUE	WED	THU	FRI	SAT	SUN
Home after school by 3:30							
Calls Mom or Dad at work by 3:45							
Plans activity ahead of time							
Lets Mom or Dad know WHERE & WHO							
Agreed upon check-in calls made							
Home by 10:30 p.m. Fri. & Sat							

REWARDS AND CONSEQUENCES

The systematic use of rewards and consequences is effective. Rewards should be an expression of appreciation for the child's efforts. Consequences should teach the child that there is a price for failing to keep the rules. Consequences must be directly related to the behavior and be agreed upon in advance by parents and children. Although a natural reaction from parents is to ground adolescents for a long time when they break a rule, there are disadvantages to this strategy. One is that the parent is usually also grounded in order to supervise the situation. Another is that the parent often ends up retracting part of the grounding, giving the child a mixed message.

Both rewards and consequences should be kept small. Used properly, small rewards and consequences have the effect of both teaching the child and decreasing the potential for conflict. The following rewards and consequences are suggested for a child 12 to 16 years old:

Rewards	**Consequences**
Later bedtime (15 minutes).	Earlier curfew (30 minutes).
Later curfew (30 minutes, 1 weekend night).	Curfew of 5:00 p.m. for 1 Saturday.
Selects dessert for family 1 night.	No telephone use for 1 day.
One dollar bonus in allowance.	Early bedtime (30 minutes for 1 day).
Parents treat to weekend movie.	Extra chore (15 to 30 minutes).

Do not expect perfection. All children forget or fail to follow through sometimes. It is important to provide the child with encouragement, even in the face of less-than-perfect performance. This will help teach the child to become gradually more responsible. Decide in advance what the criteria are for receiving rewards or punishments. This helps children know what to expect, what the limits are, and when they are doing well. Be prepared to try a reward-and-consequence system for a week at a time, and then to revise the system. This keeps the system responsive to the family's needs.

Let's now look in on a hypothetical couple discussing a plan for using rewards and consequences with their 14-year-old boy. (This couple has chosen specific parameters for rewards and consequences. These parameters may not work for you.) Suppose they are using the tracking form shown in figure 1.

Mother: "Let's take a minute to decide when we plan to reward Billy for his efforts, and what the consequences should be if—I should say *when*—he messes up."

Father: "That sounds good. Now let's see, what are we asking him to do? (Looks at the tracking form.) So there are about four or five things we want him to do each day, depending on whether it's a weekday or a weekend."

Mother: "Yes. We're asking him to do 20 to 30 things per week. Why don't we give him a small reward if he makes fewer than four or five mistakes?"

Father: "That seems about right. We know he'll slip up somewhat, but I'd like him to be able to earn the reward because I think that would encourage him."

Mother: "I agree with you on that. But what if he makes a major mistake? Say he stays out until midnight rather than 10:30, but only misses one other thing? I don't think he should earn a reward then."

Father: "That makes sense. Let's tell him that if he is home by 10:30 both Friday and Saturday nights and makes fewer than four slip-ups on the other things listed on the chart, we will give him a reward."

Mother: "Sounds good. Now, what if he is later than 10:30?

Father: "Let's ground him 5 minutes on the next weekend night for every minute he's late."

Mother: "Good idea. Let's try this for a week and see how it works. Let's talk with him after the game."

The manner in which the parents present the supervision plan to the child is a critical factor in the success or failure of the system. A negative style of communication on the parents' part is almost certain to doom the plan.

TO NEGOTIATE OR NOT TO NEGOTIATE

A central issue is whether to allow the child to have input into the system. If children have no input into the rules or consequences they are less likely to comply with the system than if they have a part in the planning. Because teenagers commonly have strong opinions about fairness, it is often helpful to ask them what their idea of a fair consequence would be. The parent will often be surprised that the child identifies an overly strict course of action.

Remember, if the goal is gradually to teach the child to be more responsible and independent, the child needs experience in formulating rules and expectations. One of the best places to practice the skills required for self-regulation is in a supportive family environment.

On the other hand, teenagers who are allowed to overrule the parents' decisions are at risk for serious problems. It is often helpful for parents to identify those issues on which they are not willing to negotiate. In the above example, the parents might decide to negotiate on the times that the child is expected to come home on school days but not on weekends. Parents should not be drawn into an argument on whether to have any rules at all. The best approach is to ask for the child's opinions and accommodate these when possible, but to ignore arguing, sulking, and bullying.

The timing of negotiation is also important. A common mistake is to negotiate about changing the rules or consequences in the midst of a problem. Once you have agreed upon the expectations and consequences, stay with these for a predesignated period of time (a week is recommended). Otherwise, you risk inadvertently teaching the child that it is beneficial to argue with parental authority.

Parents should attempt to avoid anger and sarcasm when enforcing consequences. The parent should display sympathy, acknowledging that it is difficult and a sign of maturity to accept the consequence. This reaction should be brief. Do not engage in long discussions before the consequence is completed. The time to revise the system is when there is no crisis, preferably at a brief (no more than 15-minute) weekly meeting.

REVIEW AND REVISE THE SUPERVISION PLAN

We now return to our hypothetical family. They are discussing their experiences with the supervision plan for the first week. Both parents and son would like to make changes in the system.

Mother: "Well, we've been at this for a week. What does everybody think?"

Son (upset): "I can't stand not being able to stay out later on weekends. Last week I had to leave the party before any of my friends. It was totally embarrassing."

Mother: "Okay, we'll talk about that in a minute, but first (to father), how's it going from your point of view?"

Father (to son): "All in all, you've done a real good job. You were home on time both weekend nights, and when I added up the other things on here, you hit over 85 percent. As you can see, the one area that needs improvement is planning ahead."

Son: "That's too hard. No one knows what's happening ahead of time."

Father: "Let's talk about that later. First, you get a reward for doing so well this week. What will it be: you select the family's dessert tonight, or we'll treat you to a movie."

Son: "Let's go to a movie."

Father: "Fine."

Mother: "Now, let's talk about the later weekend curfew. Your father and I would be for extending that on one night because you did so well this week. What time do you think is fair?"

Son: "Midnight."

Father: "I'm not comfortable with that yet. How about we try 11:30 this week on one night and see how that goes? Remember, Mom and I need to know where you are and who else will be there."

Son (resigned): "I know."

Father: "Okay. Let's keep the rest the same for this week, and meet again next Sunday to review things."

Mother and Son: "Okay."

Notice that in this discussion the parents did not react to the boy's negative comments. Instead, they complimented him on his performance and negotiated toward a change that he wanted. This strategy gives the boy the message that if he works within the system, he will be able gradually to get what he wants—maybe not immediately, but eventually. Had the boy argued further, the parents could have suggested that they end the meeting and regroup later when things had settled down.

The importance of parental supervision does not decrease with the child's age; the complexity of the task increases. Parents who work together, or single parents who discuss their supervision plans with other adults, will have an edge over those who try to go it alone. It is best to involve the adolescent in some part of the planning and in revising the system. As the child matures, the task of becoming independent from the family is complemented by early training in negotiation and self-regulation skills.

ROLE 7: PARENTS AS PARTNERS IN PREVENTION

Elizabeth W. Houghton

Central to any effective prevention program is the cooperation of informed parents. This section describes a specific method of bringing parents together to stimulate open communication, disseminate correct information, and build the skills necessary to prevent and reduce the use of intoxicants by youth.

Parent peer groups based on a child's friendship circle are one approach. These groups meet to communicate about parenting concerns, lend mutual support, and agree on common guidelines and rules for their children. For families dealing with specific problems, such groups are effective, but they have drawbacks as a means to communitywide change. For example, when children change friends, the peer group often fails to include new parents. When members of the group do not cooperate, frustration sets in. If families outside the group feel snubbed, they become critical, diminishing the reputation of the peer group concept in the community.

A broader structure is needed—something to attract and link all families who want to participate. A parent network based on grade levels and available to all parents within a community or school district is such a structure. A parent network is a parent-run, formal organization with an ongoing program designed to stimulate communication, offer opportunities to explore parenting issues, provide support, and develop the skills to confront unhealthy, inappropriate attitudes and practices. Ideally, a parent network becomes one facet of a community task force or a student assistance approach to prevention. It can empower parents in ways that enhance the efforts of all who work with youth.

A network can be initiated by parent volunteers or by any professional working with youth. (Other than parents themselves, probably the most effective initiator is a school administrator.) For the purposes of this discussion, it is assumed that parent volunteers initiate the network.

The first step in establishing a network within the community is to build a coalition with the schools. Approach administrators to explain the networking concept and to ask for their perspectives. At this stage, do not ask for endorsement; endorsement comes from trust, which must be earned. Realize that a dialog, not a quick meeting, is necessary to build cooperation. Evidence of network success in other communities may be requested, and administrators might be cautious until they are confident of your good intentions.

When seeking support from educators, bear in mind that in recent years school districts have had to hire attorneys to handle liability cases initiated by parents. In some communities, educators do not feel free to make even simple professional decisions without first checking into the potential liability issues.

Therefore, parents should not be surprised if they are treated initially with suspicion.

Take time to build trust; move slowly, listening carefully to educators and other members of the community. Endorsement by professionals legitimizes volunteer efforts and attracts participation. Success is most likely in communities in which a member of the power structure—probably, but not necessarily, the school superintendent—considers parents a necessary component of effective prevention.

When building a parent-school coalition, remember the school board. They have influence with administrators and can be powerful allies.

Include parent-teacher organizations. They also have influence. In some communities, parent networking is a PTA/PTO function. In others, a parent network representative is on the PTA/PTO board.

Once coalitions are built, form a planning committee to design the network and find ways to introduce it to the community. Include on the committee parents from as many segments of the community as possible, such as the police department, service clubs, and religious organizations. The more inclusive the planning group, the more effective the results. Have professionals who are not parents serve as advisors.

What specifics should the planning committee consider? First, you need a device that can stimulate dialog throughout the community. This might be a parent agreement that addresses chaperoning, curfews, the need for regular communication among parents, and the unacceptability of alcohol and other drug use by youth. By signing the documents, parents agree to communicate with other adults to ensure that events are properly chaperoned and exclude the use of alcohol and other drugs by minors. Although this type of communication is unfamiliar and difficult for many people, parents' attitudes have changed in communities where it is emphasized. Plan to introduce the agreement at a communitywide presentation that kicks off the network. Those who choose to sign the agreement become network members.

An agreement is not an objective, but a means to an end. Not all who sign it will adhere to it. In fact, pledges, agreements, and the like are relatively ineffective, except as a method of communicating to the parent community—a form of advertising—about expectations and practices. An agreement exerts mild peer pressure and offers support to parents who are uncomfortable about challenging inappropriate freedoms for youth. It also heightens the awareness of all who read it.

List the names of parents who sign the agreement on a network membership roster available only to network members. Do not publish the roster, because that appears to identify network members as the "good guys" in the community.

Instead, report in a news story the *number* of parents who joined the network. Treat those parents who do not sign with respect and under no circumstances ostracize their children. They may join later, once they see that the network's goals are sound.

The next task of the planning committee is to introduce the parent network to the community. A motivational speaker who can explain both the problems and the solutions (the network is a solution) is an effective part of a presentation. An outside expert will convey a greater sense of importance and authority than someone from the community. Select someone who is entertaining and empathic. Be sure that the speaker considers alcohol use inappropriate for adolescents and believes in systematic family and community approaches to prevention and treatment.

Seek cosponsorship for the presentation; sponsorship implies endorsement. Communities are uncomfortable with the topic of alcohol and other drugs, and sponsorship by parent volunteers alone is less likely to attract an audience than sponsorship that includes the schools. Often, local business leaders and service organizations are willing cosponsors.

Good advertising is vital to attracting a large audience. Design distinctive flyers that emphasize the solutions, not the problems. The public needs to feel comfortable about attending the program. They need to perceive that the presentation is for informed, involved parents rather than those with a problem.

Plan to distribute the agreement and an evaluation form as the audience arrives. Introduce the planning committee and announce future network activities. Allow ample time for questions and answers. Decide how to collect the signed agreements.

Effective prevention is a process, not an event. Because followup will determine network success, plan a continuous process that increases the network's membership and influence in the community. Those who did not attend the presentation can be reached with a followup mailing, which also should be sent to parents who did not hand in a signed agreement at the end of the presentation. Include an explanation of the network, a copy of the agreement, a schedule of upcoming network activities, and a return envelope for the signed agreement.

As the network progresses, recruit new leaders and members. Design programs that offer both information and skill building; awareness without skills and solutions will frustrate parents and discourage participation. Facilitated discussion groups are effective, as are role-playing workshops. If the network was formed at the junior or senior high school level, explore ways to extend it to elementary school parents. Invite input from network members by asking them to suggest program topics. Ask prevention and treatment professionals for their ideas.

Plan a year in advance, and coordinate network activities with school calendars. The task is not as enormous as it first appears. Because parents will not attend frequent meetings, plan only two or three major events per year. Small discussion groups can meet more frequently, however, if the participants wish.

Each fall, present a program to kick off the network's activities for the year and redistribute the agreement. Schools might send notices of the kick-off event in their regular fall mailing to parents.

Because communities need thorough alcohol and other drug education, programs and discussion groups should cover a variety of topics. Communication skills and building children's good self-esteem are rich subjects, as is teaching children how to say no. Offer programs that prepare parents for future situations. For example, a program for eighth grade parents about dating in high school will draw a large audience. Parents of elementary school children are interested in the influence of television, boy-girl parties, sleepovers, when to allow makeup, and the like. All parents are interested in child development issues. The possibilities are endless.

There are many sources of potential speakers. Professionals in the community are often willing to speak without a fee. A panel of both recovering and straight students discussing peer pressures usually draws a large crowd. School counselors and administrators are also good resources, and it is advisable to invest in one outside expert per year to enhance the credibility of network offerings.

As you consider forming a parent network in your community, remember the lessons learned in the prevention field. Information alone does not work. Skills for using the information must also be taught. Isolated events waste time and money and injure the credibility of the sponsoring group. Remember that good prevention is a process, not an event.

A parent network is a continuous effort that gives parents new information and skills and helps them feel comfortable communicating and taking positive action together. Change will come about slowly. The challenges we face now took years to evolve. It will take years to meet those challenges successfully. However, an active parent network can change the attitudes that have made possible the unhealthy behavior now affecting youth, families, and communities.

Communities with successful networks are beginning to feel the effects of positive change. They are learning how to invest in the future of our Nation: our youth. I encourage you to join them.

ROLE 8: PARENTS AS IDENTIFIERS AND CONFRONTERS

Michael H. Popkin, Ph.D.

Parenting isn't the only influence on a child's development, but it's the one that parents can do the most about. One of the difficult lessons of parenting is learning to accept the difference between influence and control; although we can be a powerful influence in the lives of our children and teenagers, the actual controls are in their hands. For this reason, even responsible and capable parents can have a teenager who chooses to become involved with alcohol or another drug. Effective parenting skills decrease the likelihood of this happening but cannot absolutely prevent it.

As with any other problem that life poses, how we handle a teen's involvement will influence whether the problem is solved or worsens. We as responsible parents must equip ourselves to be able to detect violations of the family no-use rule and develop a firm and caring method of confronting our teenagers.

DETECTING ALCOHOL AND OTHER DRUG USE

For any rule to be effective, the parent must be willing to expend the energy to detect violations. This means imposing curfews, knowing where children are, and being awake when they come home at night. One of the best ways to determine whether children or teenagers are breaking the no-use rule is to notice their behavior when they come in at night. It is important that parents be knowledgeable about alcohol and other drugs and the signs of use, as they are in the best position to recognize such signs in their children. Parents should respond promptly to symptoms of use.

To prepare yourself, learn about the extent of the alcohol and other drug problem in your community and in your children's schools. Meet with parents of your children's friends or classmates. Establish a means of letting each other know which children are using alcohol and other drugs and who is supplying them.

Three signs almost always mean that your child is becoming involved in alcohol or other drug use: (1) possession of drug-related paraphernalia such as pipes, rolling papers, small decongestant bottles, or small butane torches; (2) possession of drugs themselves or evidence of drugs (peculiar plants, butts, seeds, or leaves in ashtrays or clothing pockets); and (3) the odor of alcohol or other drugs or the smell of incense or other coverup scents.

There are other signs that are not conclusive in themselves, but a combination of several of these usually means that your child is not only around alcohol or other drugs but is actually using them:

- Heavy identification with the drug culture (drug-related magazines, slogans on clothing, conversations and jokes that are preoccupied with drugs, and hostility when discussing drugs).

- Signs of physical deterioration (memory lapses, short attention span, difficulty in concentration, poor physical coordination, slurred or incoherent speech, unhealthy appearance, indifference to hygiene and grooming, bloodshot eyes, dilated pupils). Again, these things are often harmless characteristics of the teenage years, but when many of these appear together, it's time to suspect alcohol or other drug use.

- Dramatic changes in school performance. A distinct downward turn in your child's grades (whether from Cs to Fs, or from As to Bs to Cs), more and more uncompleted assignments, and increased absenteeism or tardiness.

- Behavior such as chronic dishonesty (lying, stealing, and cheating); trouble with the police; changes in friends; evasiveness in talking about new friends; possession of large amounts of money; increasing and inappropriate anger, hostility, irritability, and secretiveness; reduced motivation, energy, self-discipline, and self-esteem; and a diminished interest in extracurricular activities and hobbies.

- Change in friendship groups.

Although all of these symptoms have been found to be associated with alcohol and other drug use, you should not draw conclusions on the basis of one or two of these symptoms. Look for an overall pattern of behavior.

In any discussion of detection, parents ask whether they should search a child's room. If you have reasonable grounds to believe that a child is harmfully involved with alcohol or other drugs, I believe you have the right to go through the child's belongings in search of hard evidence with which to confront the child. However, we should show our children and teenagers the same respect that the law, in general, shows us. A police officer may not come into your home and go through your belongings without probable cause and a search warrant; similarly, we ought not to make a routine habit of searching our children's belongings.

One reason that I believe that searches are sometimes justified is that it's almost impossible to find out whether teenagers are involved in alcohol or other drugs by asking them. By becoming involved, the teenager makes a decision to lie.

CONFRONTING A CHILD OR TEENAGER

Parents frequently deny the evidence and postpone confronting their children. The earlier an alcohol or other drug problem is found and faced, the less difficult it is to overcome. If you suspect your child of using alcohol or other drugs, you must first deal with your anger, resentment, and sense of guilt. Do not take your child's alcohol or other drug use as a sign that you are a bad parent. Remember that parenting is not the only influence on a child's development.

In a two-adult household, decide together about how you will handle the situation, should it arise. It is essential that you present a unified front: any disagreement between the two of you will be exploited by your child.

Do not try to have a confrontation while your child is under the influence of the drug. If your child is heavily intoxicated, do not make the mistake of allowing your child to "sleep it off."* Take the youth to a detoxification center or a hospital emergency room immediately. In addition to the medical importance of this measure, it also sends the clear message that alcohol or other drug use is serious business and is not going to be taken lightly.

Be careful not to react with rage or excessive anger. Although you may feel justified in becoming angry, a calm, firm reaction produces the best results. Trying to embarrass or humiliate your child is also likely to be counterproductive. Bribery does not work, either. The child will accept the rewards, but continue to use alcohol or other drugs. Threats and unreasonable discipline also tend to drive the child further into alcohol or other drug use.

A discipline system that works is the imposition of logical consequences. This is the same discipline skill that is recommended for other violations of rules and limits; it is taught in many parenting programs.

Sit down with your partner or with someone you trust and plan how you will confront your child. Think of the evidence you have found and decide how to present the information in a respectful, yet forceful, manner. It is important that you be able to back up each accusation with examples and evidence.

Think about your goals for the confrontation. If your child is already in the addicted or heavy use stage, your goal will be to get him or her into a treatment program. Consult your local mental health center, a physician, or a hospital that specializes in alcohol and other drug treatment. If your child is in one of the earlier stages of alcohol or other drug use, he or she still has a choice in the matter. Your goal might be to obtain an agreement to cease all alcohol or other drug use.

Be prepared for the child to try to divert you from the issue of alcohol or other drug use. Children also tend to lie or make excuses or threats when confronted. They may threaten to run away, to behave even more inappropriately, or even to commit suicide. Take any threats seriously, but do not allow yourself to be blackmailed.

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*This situation is best handled by key professionals; parents may have to go through some personal embarrassment or uneasiness about taking their child to the hospital. It must be noted that alcohol poisoning is very dangerous. Some young people have been known to mix alcohol and other drugs. There is no assurance that the child is safe until examined by a physician.

It is particularly important to treat a suicide threat seriously. More and more teenagers are committing suicide. Contact a crisis center, suicide hotline, or mental health center immediately. They can help you assess the situation and determine if the suicide threat is serious or just manipulative. Do not try to make this determination yourself.

Another guideline to keep in mind during the confrontation is to act more and talk less. Our lectures almost always fall on deaf ears when a child is already involved in alcohol or other drugs. The logical consequences that you devise and enforce will capture your child's attention.

ROLE 9: PARENTS AS MANAGERS OF INTOXICATED CHILDREN

Beth Anne Lundy
Dan Smith

There are great differences between a child who comes home intoxicated for the first time and a child whose habitual alcohol or other drug use affects the well-being of the entire family. However, both situations require immediate assessment and action on the part of the parent. At this point, parents must set aside their anger and frustration in order to make wise decisions.

ADDRESSING IMMEDIATE HEALTH NEEDS

Nothing but time will sober a person up—not a cold shower, coffee, or food. To avoid potential medical complications, remedies such as coffee, aspirin, or medication should never be given to an intoxicated person. A young person who has been drinking and is now vomiting should be taken to a detoxification center or emergency room and monitored carefully. It is not unusual for a person to fall asleep, vomit, and begin to choke. Whenever a parent wonders whether to obtain medical help, it is best to consult a physician.

Immediate medical help should always be sought for anyone who has consumed a large amount of alcohol and is unconscious or semiconscious. It should never be assumed that the child is "just drunk." Unlike adults, who generally use one drug at a time, youngsters often use alcohol in combination with a variety of other drugs. The combined effects of two or more drugs cause multiple problems.

For example, consider the combination of alcohol and marijuana. The body's natural response to the consumption of too much alcohol is to get rid of the poison by vomiting. But, because one of the effects of marijuana is the suppression of the body's vomiting mechanism, alcohol stays in the system of a person who has used both drugs. The high concentration of alcohol in the blood and stomach can cause poisoning and even death.

Parents who suspect that their child has been taking barbiturates or other depressants, either alone or with alcohol, should call for immediate medical help. The user should be kept walking and talking in order to maintain consciousness. Neither coffee nor medication should be given. Depending on the amount of drugs the person has taken, the stomach may need to be pumped.

Drugs such as crack, PCP, and LSD can cause a variety of reactions depending on dosage level, purity, the user's emotional state, and the environment. One of the common effects of PCP use is that the person has increased strength and is easily provoked; violent acts are common. If PCP use is suspected, the user should be isolated as much as possible to protect both the user and others. Anything that might stimulate the person's senses, such as bright lights or loud

80

noises, should be kept to a minimum. Medical authorities should be notified immediately and informed that PCP use is suspected.

DELAYING CONFRONTATION

Attempting to discipline a child under the influence of drugs is pointless. Parents often say things they later regret, and the child is certainly not in a frame of mind conducive to listening and understanding. Parents should let their child know that the situation will be discussed in the morning (or when the child is sober) and leave it at that.

Delaying the confrontation does not mean forgetting it. If the situation is not addressed, the message is that the parent is willing to tolerate the child's behavior. Avoiding confrontation almost ensures that the behavior will be repeated.

Parents should vent their frustration on paper. Both the facts regarding the child's behavior at the time of intoxication and the parent's feelings should be addressed. This will not only help the parent to be objective when discussing the situation with the child, but also help the child to view the situation realistically.

For example, a parent might write the following:

At 2:00 a.m., two hours after your curfew, we woke up to a honking horn and screeching tires. I was worried about you and embarrassed to think that the neighbors also had been rudely awakened. Moments later, as your friends drove away, you came stumbling to the front door. Unable to find your key, you pounded on the door until I opened it. You cursed at me and defended your right to "just have a couple of beers after the football game." You fell asleep on the couch. In the morning, I was disgusted to see that sometime in the night you had urinated in your clothes.

KEEPING THE EVIDENCE

Too often, parents protect their children from the consequences of their behavior by disposing of the evidence—cleaning up their vomit, changing bed sheets that have been urinated on, reparking the car so that it is not half on the driveway and half on the lawn. Protecting children from embarrassment may actually further their alcohol or other drug use.*

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*Instead of cleaning up the young people's messes, have them take care of it themselves. The message is clear that the parent knows what happened and will not cover up for the child or deny the issue.

FOLLOWING THROUGH

When children are no longer intoxicated, they should be confronted. Parents will probably hear such responses as, "Do we have to do this now? My head is killing me. It's no big deal!"

Although some of the emotion and sense of urgency may have dissipated, it is imperative that parents follow through on their commitment to recognize the situation and allow their child to experience the consequences. Rules of the household should be reestablished, including the consequences for further incidents. Most important, any consequences or guidelines established prior to the incident must be enforced.

Denying that an alcohol or other drug problem exists despite ample evidence is detrimental to both the family and the user. Denial clouds the vision of otherwise objective adults and restrains people from taking action. This behavior is common in families dealing with chemical use. But part of the healing and recovery process is recognizing that a problem exists and admitting that help and support are needed. By the time most families acknowledge a chemical dependency, the problem has progressed to the point that professional intervention is required.

SEEKING PROFESSIONAL HELP

The following points should serve as warnings to seek professional help in assessing the nature and extent of a child's alcohol or other drug use:

- The child has promised to quit but has not.
- The child has been suspended from school or arrested because of alcohol or other drug use.
- The child continues to use alcohol or other drugs even after the parents have instituted severe consequences.
- The child engages in increased risk-taking behavior: selling drugs, possessing drug paraphernalia, bringing drugs home, coming home intoxicated, or taking drugs at school.

Successful therapy can be accomplished in an outpatient or inpatient setting, depending upon the person's needs. When a person has been using alcohol or other drugs for a long period of time, inpatient treatment may be the best alternative. Occasional users who are motivated can respond equally well to outpatient therapy. The cost of programs, which is a consideration for most parents, varies greatly. These alternatives should be discussed with an unbiased, qualified therapist who has assessed the user's needs. Any treatment program should include the following components:

- Specialization in *adolescent* chemical dependency.

- Treatment of the person's alcohol and/or other drug problem.

- An abstinence contract (a no-use policy *that includes alcohol* is essential).

- Supervision by qualified, licensed personnel. This should include medical staff, therapists, and an education program for inpatient care. The ratio of patients to staff should be taken into consideration.

- Inclusion of the entire family in the treatment process.

- Commitment to aftercare support for at least a year.

- Incorporation of continuous support groups such as Alcoholics Anonymous and Narcotics Anonymous.

- Reconstruction of each area of social life: family, school, friendships, and leisure time activities.

- Behavioral contracts and random drug testing are possible additional components.

ROLE 10: PARENTS AS MANAGERS OF THEIR OWN FEELINGS

Beth Anne Lundy
Dan Smith

When children become involved with alcohol or other drugs, parents begin to search for answers. Often parents blame themselves: "What went wrong? Where did I fail? How could he do this to our family's reputation? After all we've done for her, how could she treat us this way? Why didn't I see this coming?"

It is paramount that parents learn to acknowledge and manage the flood of emotion that accompanies the discovery of their child's alcohol or other drug use. As parents work through their feelings, anger is usually in the forefront. Anger that is not dealt with can create a number of problems. Besides the possibility of physical violence, parents' anger toward their child or themselves can prevent productive action such as seeking help.

Children almost always act defensively when their alcohol or other drug use is discovered. They both deny the facts and distort them. Children who are on the defensive are experts at manipulating their parents' guilt feelings. Children who can make their parents feel partly responsible for the problem have a better chance of being able to continue using alcohol or other drugs.

All parents make mistakes, but feeling guilty will not change the current situation. Parents need to be reminded that their child's decision to start using alcohol or other drugs was made independently. A slight sense of guilt can provide motivation for action, but too much guilt can overwhelm parents and keep them from taking charge. Parents can increase the possibility of a successful confrontation by following the guidelines below.

LEARNING TO EXIT RATHER THAN EXPLODE

Often, parents are too upset with their children to deal rationally with the problem. Physically leaving the situation can prevent people from saying things they would later regret. Any activity that allows people to vent some frustration and gives them time to think things through can be beneficial—taking a walk, yelling and screaming in a closed room, beating on a pillow, or calling a friend to talk things out. Separating emotion from the facts of the incident will help to increase the chances for success in the pending confrontation.

LISTENING WITHOUT ABSORBING GUILT OR ACCEPTING EXCUSES

The concept of listening is certainly important in parent-child communication. Children benefit from an environment in which their opinions and ideas are considered and valued, even if different from their parents' viewpoints.

However, there is a difference between listening to what children have to say and accepting their excuses. Children who are using alcohol or other drugs do everything possible to protect their valued friend—the drug. Parents have a right to set realistic guidelines and expect them to be followed.

STANDING FIRM

When parents discuss alcohol and other drugs with children who are using, disagreement is inevitable. Although parents cannot control their children's attitudes or beliefs, they can and must expect certain behavior. Making use of the words "regardless" and "nevertheless" can help a parent avoid circular arguments, as in the following example:

Child: "All my friends smoke dope!"

Parent: "Nevertheless, drugs are illegal and you are not allowed to smoke dope or use any other drugs."

Child: "Mike's parents let him stay out late and drink beer."

Parent: "Regardless of what Mike's parents allow, you are not allowed to stay out past 10:00. Furthermore, you are not allowed to drink beer or any other form of alcohol; *it is illegal.*"

FORGIVING

Parents and children alike need to know that there is hope—both for themselves and for their family unit. Once feelings have been appropriately expressed and consequences for the child's behavior have been identified, new opportunities for building trust can begin.

ISSUES OF CONTROL AND CHANGE

Parents can control only their own actions. Their children's actions (and the consequences thereof) are the children's responsibility. Many times, parents want help and relief from the problems associated with alcohol or other drug use long before the adolescent does. Parents who seek help for themselves, regardless of their children's behavior, can learn to relinquish their feelings of guilt and anger and build healthier attitudes. Through support groups, therapy, or both, parents can learn to focus on the children's behavior rather than their characters, identify and stop behaviors that enable or help the user to continue alcohol or other drug use, and rebuild the family's mutual respect and support, which inevitably suffers in a chemically controlled environment.

Chapter 4:
Appropriateness and Cultural Competency: Crucial Elements in Parent Training Programs

Michael Cunningham

Much of the research literature has identified family processes and childrearing practices as both risk and protective factors for alcohol and other drug use among youth. These processes and practices differ based on ethnicity and culture, as do the style, degree, and manner of family involvement and attachment. In general population studies, family attachment and involvement have been related to the use of alcohol and other drugs. Ethnic differences in perceptions and attitudes regarding alcohol and other drug use, its consequences, and resolution may be factors in the quantity, frequency, setting, and context of alcohol and other drug use. The relationship between family attachment and involvement and alcohol and other drug use may be correlated with ethnicity.

These research findings suggest that ethnicity and culture are of critical importance in the design and implementation of parent training programs. To be effective, programs must be ethnically appropriate to the needs of the recipients. In addition, the presenters of the program must themselves be culturally competent. Failure to address ethnic appropriateness and cultural competency will severely limit the ability of the program to attract ethnic participants and effectively respond to their alcohol- and other drug-related parent training needs.

Ethnicity and culture must guide (1) development and selection of parent training programs; (2) adaptation and modification of existing programs; (3) selection and training of presenters; and (4) the who, what, when, where, and how of program implementation. Cultural integrity is essential, and the involvement of existing leaders from within the ethnic community must be emphasized.

The following discussion addresses a number of elements germane to achieving ethnic appropriateness and developing cultural competency. These can best be achieved by developing programs specifically for and with the ethnic group targeted and by using presenters who are themselves members of the target ethnic population and community. The lack of either or both of these components can reduce the effectiveness of a program. Therefore, careful consideration should be given to the relative merits of using an ethnically "specific" program versus an ethnically "sensitive" program, using indigenous members of the ethnic group and community as trainers versus using nonmembers of the ethnic group who are culturally competent, and using community members versus members of the ethnic group who are not a part of the community to be served.

DEFINITIONS

Considerable confusion and inaccuracy exist regarding the meanings of terms used to describe ethnic-related information. To develop a common understanding, we must first achieve consensus on the meanings of terms. The following definitions are offered to help specify relevant concepts:

- Ethnicity: the designation of a population or subgroup having a common cultural heritage as distinguished by customs, characteristics, language, and common history.
- Culture: a set of values, attitudes, and practices held in common by a group of people, usually identified by ancestry, language, and geography.
- Race: populations distinguished by physical traits such as hair texture, eye shape or color, skin color, and body shape. Main divisions are Negroid, Caucasoid, and Mongoloid.
- Ethnics of color: individuals, groups, families, clans, tribes, and races of people whose national origin or culture is non-Caucasian, and who are identified and distinguishable as a result of their non-Caucasian ancestry.

SIGNIFICANT CONSIDERATIONS IN PROGRAMS FOR ETHNICS OF COLOR

Parent training programs to reduce alcohol and other drug problems among ethnics of color must take into consideration that the number, type, and consequences of alcohol and other drug problems are related to ethnicity. The ethnic-related factors that must be considered include the following:

- Lifestyle and risk factor exposure
- Genetic factors
- Knowledge of good health practices
- Greater incidence of hazardous occupations and environmental exposures
- Negative health consequences of low socioeconomic status
- Norms for use

Limited access to health information, hazardous occupations, and low socioeconomic status affect some ethnic groups disproportionately, but it cannot be assumed that all ethnics of color experience these risk factors.

In addition to ethnic-related differences in the potential for alcohol and other drug problems, there are also ethnic differences in how problems are identified, experienced, and responded to, and what those problems are. Parent training programs for ethnics of color must effectively address the following characteristics of the target populations:

- Experience of problems
- Labels for symptoms or indicators
- Communication of problems
- Beliefs about problems and their causes
- Attitudes about health care providers
- Expectations about treatment or assistance
- Personal involvement and responsibility

These norms, behaviors, and attitudes within the ethnic group and community to be served should significantly affect program development and implementation.

CROSS-CULTURAL ISSUES

Although ethnically specific programs presented by members of the ethnic group and community to be served are the ideal, cross-cultural programs and trainers are often necessary due to the limited number of ethnic-specific parent programs and the limited training available for ethnic trainers. Furthermore, no ethnic group or community is or should be isolated from others. It is important to address cross-cultural issues in order to maximize the effectiveness of programs.

Programs must first recognize the tremendous differences in how different ethnicities and specific ethnic communities relate to one another. Ethnic groups and communities differ in their definitions of their own identity as well as their attitudes, beliefs, and behavior regarding other ethnicities. And within any given ethnicity or ethnic community, individual members differ markedly in attitudes, beliefs, and behavior.

Listed below are developmental stages for social group identity. Close attention should be paid to assessing where the presenter and ethnic community to be served fall along this continuum. The stages are as follows:

- **Lack of social consciousness**, which describes absence of consciousness of racial, ethnic, or gender membership.

- **Acceptance**, which refers to acceptance of socially assigned roles for one's own group and others, including all the positive and negative stereotypes.

- **Resistance**, which denotes heightened sensitivity to racism and sexism whether in one's own attitudes and behaviors, at job or school, or in general environment.

- **Redefinition**, which describes efforts of members of various social groups to redefine themselves in ways that transcend negative stereotypes they formerly either embraced or reacted against.

- **Building bridges**, which refers to attempts to build bridges between one's own group and the people and organizations around it.

The results of the assessment should be used to guide program and presenter selection, presenter training, and program modification.

ETHNIC AND CULTURAL BUILDING BLOCKS

Ethnicity and culture can serve as building blocks to developing and implementing effective parent training programs. Ethnic building blocks include the following:

- **Cross-cultural understanding** recognizing many culturally determined viewpoints and standards of behavior. This includes specific knowledge of and respect for differences, particularly as they affect daily interactions between and among members of a particular culture/ethnicity and members of another culture/ethnicity.

- **Linguistic pluralism** that accepts more than one language as a legitimate means of communication among members of a given community, State, or Nation.

- **Attention to ethnically/culturally appropriate learning and problem-solving styles**. This involves recognition that a variety of strategies and approaches can complete a given task. To an extent, learning and problem-solving styles are culturally determined. The use of a variety of approaches appropriate to the target population should be encouraged.

- **Culturally appropriate qualitative skills**, such as warmth, respect, sincerity, concern, caring, concreteness, and immediacy. Manifestations of these skills vary among different cultures.

ETHNIC AND CULTURAL STUMBLING BLOCKS

Program stumbling blocks related to ethnicity and culture include the following:

- **Language,** involving failure to use appropriate style, manner, and content of communication for the target group.
- **Class-related values** reflected in failure to recognize the usefulness, desirability, importance, or worth of something for a group of people within a particular economic or social stratum of society.
- **Culture-related values** involving failure to recognize the importance, usefulness, desirability, or worth of something for a group of people having a set of shared attitudes and practices.
- **Nonverbal communications** demonstrated by failure to use ethnically and culturally appropriate nonverbal skills such as eye contact, body language, and physical closeness.
- **Stereotypes** reflecting conscious or unconscious attribution of exaggerated characteristics and/or oversimplified opinions, attitudes, or judgments to members of a given ethnic group or culture.
- **Racism** expressing an attitude that defines certain culturally or ethnically identified groups as inherently inferior to others and legitimately subject to exploitation, discrimination, and various types of abuse. Racism can be systemic when it is pervasive throughout the economic, political, or social structure of a community, State, or Nation. It is structural when it is institutionalized within various systems in a given community, State, or Nation.
- **Ethnocentricity** involving an attitude that one's own ethnic group or culture is better than others, or failure to recognize the existence or validity of other ethnic groups and their customs, values, beliefs, and norms.

GUIDELINES FOR PROGRAM DEVELOPMENT

To be effective, parent training programs, services, and trainers must meet the five As:

- Accessibility
- Availability
- Acceptability
- Affordability

- Accountability

The extent to which a parent training program achieves the five As in alignment with the needs of an ethnic population determines its ethnic appropriateness. The importance of ethnicity and culture is manifested in the attitudes and values that we display. The box below provides information on attitudes and values that support and reinforce sensitivity and respect for the ethnic group to be served.

Ethnically and Culturally Sensitive vs. Insensitive Attitudes and Values

Sensitive	Insensitive
Do with	Do for
Work alongside	Lead
Assist	Control
Provide input	Advise
Facilitate	Determine
Provide additional resources	Impose additional requirements
Encourage	Mandate
Respect	Condescend
Display concern	Display paternalism
Demonstrate empathy	Demonstrate sympathy

GUIDELINES

The preceding discussion has highlighted a number of issues that must be addressed in developing ethnically appropriate parent training programs. The following guidelines are based on a consideration of those issues:

- Implement programs that are both ethnically sensitive and ethnically specific.
- Use nontraditional leadership and service delivery systems that are appropriate to the needs, norms, and values of the target ethnic group and target community.
- Share responsibility with community and other systems for the design and implementation of an effective program.
- De-emphasize traditional arguments (such as high incidence of alcohol and other drug problems for a particular ethnicity) as the basis for implementing ethnically appropriate programs. Focus instead on the goal of facilitating

healthy growth and development for both individuals and communities by providing ethnically appropriate services and programs.

- Establish minimal objectives that are challenging, realistic, and achievable. Accountability for achieving the objectives should rest with the community as well as the organization and/or funding source.

Ethnic and cultural competency and appropriateness are cornerstones in the development and implementation of an effective parent training program. They must be an integral part of every effort, from planning through evaluation.

Chapter 5:
How To Get Hard-To-Reach Parents Involved In Parenting Programs

Karol L. Kumpfer, Ph.D.

Many families live in situations that place them at high risk for alcohol and other drug use problems. These situations may be socioeconomic, environmental, or other factors that affect healthy growth and development. Not only are the children in these families at high risk for alcohol and other drug problems, the parents are, too.

HIGH-RISK AND HARD-TO-REACH PARENTS

Although recruiting high-risk children is not easy, once the word gets around the community about a new children's program, parents are generally eager to have their children attend. Getting the parents involved is another matter, however. Despite almost universal agreement that involving parents or family members in parenting or family interventions with high-risk youth is more efficacious than working with the children alone, there are practical barriers to the former. The primary barrier is the difficulty of getting parents or family members to attend even the first few sessions of the program.

Some agencies have found that many parents of high-risk youth agree to attend the program when asked but do not show up. The causes for these attendance problems are many and include reasons that the parents will openly discuss (such as child care, illness, transportation problems) and unstated reasons that the parents themselves may not understand. And many parents do not feel they need to improve their parenting skills or family relationships.

BARRIERS TO PARENTAL INVOLVEMENT

The first step in addressing recruitment and attrition issues is to analyze the barriers to parental involvement. The following factors are common barriers:

- Costs
- Transportation
- Child care

- Time
- Lack of interest in parent training
- Lack of program ownership
- Cultural differences between providers and parents

Another major reason for failure to engage high-risk parents is fear. They are often fearful of social service agencies, protective service action, strangers, new ways of parenting, talking about personal issues, and being labeled as a bad parent. Fear associated with the sponsoring agency or the location of the sessions can also reduce attendance. Cultural and socioeconomic differences between the staff and the participants can also reduce involvement.

Some parents do not understand the efficacy of psychosocial skills training or parenting groups. The idea that their style of parenting has any connection with the child's behavior is a foreign concept for some parents. Parent trainers who do not understand this view of children's behavior can be ineffective. Denial is pervasive among high-risk parents.

Another major barrier to engaging parents in parenting groups is time. Parents who have basic problems of their own (housing, food, medical care, safety, drug addiction) seldom have time to participate in parenting programs. Many programs for high-risk, low-income families first solve the family's primary needs before conducting the parent training. Any community agency recruiting high-risk families for parenting programs should examine its internal and external referral resources to meet these basic needs. Case workers should allow several months of social services before parent training is provided.

For many people, parenting is private and personal. They do not want outsiders telling them how to raise their children. This does not mean that they do not want to do it well; it is that outsiders are not respected or trusted.

STRATEGIES FOR ADDRESSING EACH BARRIER TO PARENTAL INVOLVEMENT

Incentives for involvement are often needed for hard-to-reach parents. Successful strategies are discussed below as well as some untried strategies. These strategies can help community agencies include enough recruitment and attrition-reduction resources to make the program successful.

Cost

Although participation fees sometimes help increase commitment to the program among middle-class parents, fees reduce attendance among low-income parents. Programs have found that incentives for involvement have been helpful in recruitment efforts. Paying parents to attend the first session and offering a bonus for completion of the program sometimes works. Some providers offer gift certificates to parents who complete the program. More affluent parents can pay a deposit for the cost of the program, a portion of which can be refunded as they complete each session or the total program.

Transportation

One solution to this problem is to offer parenting classes in locations such as parents' own homes, community centers, churches, businesses employing large numbers of high-risk parents, child care centers, residential treatment facilities, jails, and prisons. If this is not possible, some programs consider arranging car pools, providing bus or subway tokens, or offering van services. Sometimes program alumni will volunteer to be coleaders and can be used to pick up clients. In any case, before providing transportation, a lawyer should be consulted about liability issues.

Child Care

Hard-to-reach parents often are socially isolated, single parents with a number of children. Programs can provide child care or, even better, run a structured children's skills training group at the same time as the parenting class and end with positive family time. To reduce the cost for child care trainees, former program graduates, senior citizens, or van drivers can be used to run the children's groups. These staff need to be trained and supervised in their duties, and screening is necessary to ensure that staff are qualified to work with children.

Time

Ways to decrease parents' time investment include holding the parenting session prior to a meeting that the parents regularly attend anyway, such as that of a church group, social organization, Alcoholics Anonymous, or therapy group. Free child care might be offered during the regular meeting to parents who have attended the parent training group. Other strategies are to offer parent training at worksites during lunch hours or to show parenting videos while parents wait at general assistance offices or medical facility waiting rooms. Some programs provide self-help parenting workbooks to parents who do not have time to attend the groups.

Recruiters may have to work with potential clients to help them find time for a parenting program. If clients who cannot attend have access to a videotape machine, they could at least participate in a videotaped program. Greater availability of parent training programs on television and cable television would help to reach more of these parents.

LACK OF INTEREST IN PARENT TRAINING

In some cases, program recruiters must first discuss with parents the benefits to them of attending parent training. Interest can be developed through targeted marketing strategies. Parents' goals must be understood before parents are told how the program will help them and their children to meet their personal goals. Outreach educational sessions on the value of parenting can be offered in any location or agency to which hard-to-reach parents have access.

Parents should be educated on the need to reduce risk factors for high-risk children and on what these risk factors are. They could rate their children on a short risk assessment such as the one developed by Dr. David Hawkins and his associates at the University of Washington. Parents can be educated through talks at local churches, schools, treatment clinics, booths at community fairs, street fairs, and grocery stores. Respected members of the community and local cultural leaders can assist in recruitment. A short parenting questionnaire can help parents decide if they need to take a parenting course. They can take the test and score it themselves with the answers and read their results to the group. A low score on the test may encourage parents to take the parenting course. Posters on the availability and benefits of parent training can also help. Brochures, flyers, posters, and other recruitment materials should be culturally specific.

Generally, the most effective method for accessing hard-to-reach parents is personal contact. Program alumni can be helpful in recruiting friends and acquaintances by talking about the improvements they have noticed in their parenting skills and their children's behaviors. Alumni could be paid a bonus for each new parent recruited to the program. Some parenting programs hold recruitment parties or have potential participants attend a graduation party for their friends. This also helps break down parents' fears of the agency and staff by allowing them to meet on a happy occasion. Case workers, protective services workers, therapists, ministers, or other helping professionals can sometimes encourage their clients to attend if there is a close relationship. It is important to inform such professionals of the availability of the parent training courses.

Sometimes a child's teacher or principal can explain to parents that a child is at high risk for problems such as alcohol and other drug use and delinquency. Protective service workers, case workers, therapists, judges, probation or parole officers, and others working with parents who have already abused their children, or whose children have been involved with law enforcement, can help to interest parents in training. Judges can order parents to attend parent training classes. Often these courses are too little, too late for a child in custody, but can help younger siblings not yet in trouble. There is no evidence that obligatory involvement reduces the effectiveness of training. Whatever it takes to get hard-to-reach parents involved appears to work if the course is tailored to their needs and trainers can engage their interest.

Some parents are motivated to attend parenting courses when crises occur in the family that could be resolved by more effective parenting. For this reason, parent training is often included in crisis services, such as in-home family preservation programs. Parents who are in imminent danger of having their children removed from their care are often motivated to change their parenting behavior.

Fear Of Sponsoring Agency

Parents will not attend a training program if they do not trust the providers. Some community organizations have established a good reputation with hard-to-reach parents and others have not. If the provider's organization is viewed as not really caring about or understanding their needs, parents will not attend.

Recruiters and trainers must develop a relationship of mutual trust and respect with potential parents. This requires a great investment of time and effort. Some recruiters go to schools, homes, street corners, and stores to talk with potential participants. Parents should be addressed as Mr., Ms., or Mrs. rather than familiar first names.

Fear Of Protective Services Action

Parents' fear of State intervention and loss of their children is another reason to develop a trusting relationship with clients. Explain the confidentiality regulations of the sponsoring organization, but also explain reporting requirements in a "mini-Miranda" declaration (written or oral). The organization has an ethical obligation to inform the parents and children that if they disclose any information about sexual or physical abuse, the State authorities will have to be notified. This should be done in a way that shows that the providers have their clients' welfare in mind.

If a parenting program also involves children's social skills training groups, children often encourage their parents to attend so they can go to the children's group.

Lack Of Program Ownership

A sense of parent ownership of the program can be fostered by involving parents in program leadership, staffing, modifications, resource development, and participant recruitment. A parent advisory group comprising alumni as well as influential community members of the same ethnic group can generate suggestions for improving recruitment and attrition problems and assess program effectiveness and cultural appropriateness. Trusted community leaders can help with recruitment and reduce fear of the sponsoring organization. If parents in a target community feel that the program is theirs, they will make sure that it continues regardless of the current funding source. They can be helpful in lobbying for and raising funds.

Cultural Differences Between Providers and Parents

Some high-risk parents do not attend parenting groups because of discomfort due to cultural differences between themselves and the program providers. The previous chapter discusses specific considerations related to cultural specificity and sensitivity.

RECRUITMENT STRATEGIES FOR SPECIAL POPULATIONS

Different recruitment strategies may be needed to recruit special populations of parents, such as teen parents, migrant worker parents, adoptive or foster parents, housing project parents, addicted parents, parents of children in special education, and others. Specific tips for dealing with each special population are provided below.

Teen Parents

Adolescent parents often do not want to be in parenting groups with older parents. It may be wise to have a special group for teen parents only. Teen parents can be recruited from special programs in regular or special schools. Welfare or social service agencies often have contact with teen parents who dropped out of school. Teen parents can be recruited through brochures and announcements sent to them from a hospital or recommendations from their doctor or public health nurse. Some hospital social workers or public health nurses conduct in-home parenting sessions for teen parents.

Migrant Workers

Parents who move around are particularly difficult to recruit. Migrant health projects sometimes have mobile units and offer parenting classes in the fields. Some family services agencies have parent trainers conduct groups at work sites. Employer support should be encouraged.

Addicted Parents

These parents can be recruited from treatment clinics if they are in treatment. Parents going to daily methadone maintenance clinics are often interested in parenting courses if encouraged by their therapists to attend. As mentioned above, it is beneficial to offer child care to parents who attend a parent group.

Parents Of Children In Special Education

These parents can be recruited through school teachers or counselors. Parenting courses have been offered for some time for parents of children with emotional problems, particularly those in special mental health programs. Because the children are so difficult to handle, most of these parents are willing to attend parenting groups. For those parents who are not, the special recruitment strategies mentioned should work.

Adoptive Parents

Parents who have adopted older or special needs children often look for parenting classes. These classes can be advertised through adoptive parent organizations' newsletters and parent support groups.

Foster Parents

Special parenting programs for foster parents have been used for many years. Foster parents generally are interested in learning how to be better parents for special needs children. They can be recruited through the agency that supports their foster parenting.

Housing Project Parents

Parents in housing projects must be allowed time to build trust in the service provider. A strong tenant's organization and onsite social workers can be employed to help organize a parent training group. Head Start projects in housing projects sometimes offer parent training. In-home parent training is sometimes available. Parent support groups, dropin centers, and afterschool children's programs can be used to recruit parents.

ATTRITION ISSUES AND PROMISING STRATEGIES

Program length is positively associated with effectiveness. Therefore, it is a necessary element to reduce attrition rates. Once parents have attended two sessions, they are likely to continue attending since barriers to attendance have been removed. However, there are often unavoidable reasons for attrition, such as illness, death in the family, incarceration, relocation, and entry into inpatient alcohol or other drug abuse treatment centers. Because of the high incidence of personal crises among high-risk families, at least 1 or 2 families out of 10 should be expected to drop out. Higher attrition rates are common among some very high-risk groups, such as homeless families, alcohol and other drug abusers, and teen parents.

Common causes of attrition include the following:

- Unexpected crises

- Forgetting and other demands on time
- Program's failure to meet needs or accord with world view of parents
- Fear of group interaction and personal disclosure
- Lack of group cohesion
- Trainers' lack of appeal

Unexpected Crises

For parents with short-term crises, program providers should be flexible enough to provide individual makeup sessions. Parents should be encouraged to notify the trainers if they will be absent from the group.

Forgetting and Other Demands On Time

A telephone tree helps parents remember to attend. Trainers and other parents can remind members to attend either by calling them or by sending postcards. Some groups even have a group member or trainer write notes on each parent meeting or develop a weekly newsletter and send it to all members just before the next meeting. This reminds the parents of the group and the topics to be covered. Trainers should telephone parents who do not attend, being sure to call within the first day or two of their absence and expressing how much they were missed. It is important to make known how much the program providers care about parent's participation and to determine and resolve their barriers to effective time management.

Program's Failure To Meet Needs Or Accord With World View Of Parents

If the program does not reflect the world view of the parents and their cultural reality, they will drop out. The reading level of the parents should be determined and the reading assignments and homework exercises adapted accordingly. Cultural issues are discussed in the preceding chapter.

If the parenting program does not address the major parenting issues of the participants, they will stop attending. A needs assessment or pretest can determine the primary needs of the target group. Periodic feedback from the participants' exit interviews and client satisfaction surveys can help to ensure relevance. The alumni advisory board can also monitor program activities.

Most parents want to learn how to get their children to do what they tell them to do. With high-risk families, it is generally not a good idea to give them what they want too soon or they will drop out after the initial sessions. However, to continue coming, they must see that they will learn what they want to know before the parent program ends.

Fear Of Group Interaction and Personal Disclosure

Some hard-to-reach, insular, or minority parents are uncomfortable with personal disclosure and intimacy in parenting groups. Trainers must be sensitive to these feelings and not demand too much. Parents also feel uncomfortable if they do not understand how to complete homework assignments and group exercises. Some high-risk parents will be overly responsive to the chance to talk about their problems and may take too much of the group's time. Trainers have to find the right balance between skills training and the personal need of some parents to discuss their lives. For some parents, there will not be enough time for personal sharing and disclosure, while for others there will be too much. Humor and fun activities lighten the mood and make the group enjoyable.

Lack Of Group Cohesion and Bonding

If the members of the group like each other and the trainers, they will begin to support each other. This type of group bonding can be enhanced by the trainers by developing a group identity and name and encouraging special humor or language in the group. Group-building activities should occur early in the program. Collages of pictures of the participants, alumni gatherings, continued social support, and followup sessions are good ways to promote a sense of community. When group bonding occurs, the attrition rate drops; no one wants to let the other members down by not attending.

Trainers' Lack Of Appeal

The inability of trainers to capture parents' interest can reduce attendance. People from many different disciplines—graduate students, undergraduates, and volunteers—can all make good trainers if they have personal appeal and warm, genuine, empathic personalities. They also need to be able to teach and provide useful information in a confident manner.

SUMMARY

This chapter has presented a variety of strategies for getting high-risk parents involved in family-focused prevention programs. Each of these involvement strategies has merit and is useful depending on the particular barriers for involvement and the degree of family dysfunction. In addition, the resources of the agency delivering the services should be considered in the choice of the most appropriate strategies.

Chapter 6:
Sample Program Descriptions

This listing of parent training programs is representative of the instruction and guidance available today. All of the programs described either have or are in the process of developing components that directly address the issue of alcohol and other drug use. This listing is not meant to be exhaustive, but to give an idea of the types of programs available. The basic goals and methods of each program are enumerated, and a source of further information is given in each entry.[*] The following programs are described:

Active Parenting
Applause
Black Parenting Education Program
Child Behavior Institute
Children and Home
Confident Parenting
Effective Black Parenting
Effective Parenting Information for Children
Epac Parent Training System
Families In Touch
Project Head Start
A Look at Adolescents
Los Niños Bien Educados
The Nurturing Programs
Parent Effectiveness Training
Parent to Parent
Parenting: The Underdeveloped Skill
Parenting: Your Child From 1 to 6
Positive Indian Parenting
Preparing for the Drug (Free) Years
The Step Programs
Strengthening Families
Talking With Your Kids About Alcohol

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[*] Many of these programs have been thoroughly evaluated for their use and replication in a variety of settings. It is recommended that any inquiry about these programs include questions about documentation of evaluation. In all cases, the contact person will be able to provide up-to-date information on evaluation and current program innovations.

TITLE:

The Active Parenting Video/Discussion Program and The Active Parenting of Teens Video/Discussion Program

CONTACT INFORMATION:

Active Parenting Publishers
810 Franklin Court, Suite B
Marietta, GA 30067
(800) 825-0060

DESCRIPTION:

Published in 1983, the original Active Parenting Video/Discussion Program teaches a method of parenting and problem solving that enables parents to help their children develop self-esteem, courage, responsibility, and cooperation.

The Active Parenting of Teens Video/Discussion Program, published in 1990, answers the special needs of parents to instill in their teenagers the same essential qualities mentioned above. It also goes further in that it teaches parents to apply their active parenting skills, such as discipline, communication, encouragement, and problem solving, to the critical issues of drug use prevention and teen sexuality. Active Parenting of Teens integrates the recommendations of OSAP's expert panel on parenting as prevention, including the 10 roles parents can play in the prevention process.

A video-based discussion format is used in both programs. Forty-five brief, professionally acted videovignettes depict typical scenes from family life and model the skills to be taught. The videos are fully integrated with class exercises, discussion, role playing, readings, practice, feedback, and home assignments. The program comprises six 2-hour sessions. Most groups meet weekly.

INSTRUCTOR QUALIFICATIONS:

The essential qualification is effectiveness as a facilitator. The ideal leader has experience in small group leadership and a commitment to parent education.

INSTRUCTOR TRAINING:

One-day leader certification workshops are available at $95 per person. In addition to 8 hours of instruction, each participant receives a Leader's Guide, Parent Handbook, Action Guide, and Promotional Guide. Certification is not required to lead groups.

MATERIALS:

Each of the Active Parenting Discussion Programs consists of a Leader's Guide, Parents Guides, a Promotional Guide, course announcement posters, and 25 parent brochures. The original Active Parenting Program includes a 95-minute videotape and a 17-minute video preview. The teen program includes two videotapes (total time: 184 minutes) and a 10-minute preview tape. The total price for both programs is $540 plus $15 shipping. Each program is also available in an all-video format for $295. This includes six separate videotapes that can be lent to parents.

TITLE:

Applause

CONTACT INFORMATION:

Andrea Stevens Lavigne
Director
Metro Toronto Health Promotion Centre
175 College Street
Toronto, Ontario
M5T 1P8
Canada

DESCRIPTION:

The purpose of the Applause program is to increase parents' awareness of and interest in preventing, identifying, and coping with children's alcohol and other drug use. Applause is a short-term educational intervention designed for parents with high school education and low to moderate personal alcohol consumption. Children's ages do not matter. Presenters use the Applause manual and accompanying slide package in a 1 to 1½ hour presentation to a group of parents. Although skill development is not possible in this timeframe, the importance of specific skills such as verbal confrontation, listening, rule development, modeling, and consequence management is emphasized. Parents are encouraged to seek additional information and opportunities for skill development. Preferred group size is 20 to 25 parents.

INSTRUCTOR QUALIFICATIONS:

Instructors generally work in the field of health promotion or addictions. They should be skilled in presenting material and in facilitating group discussion.

INSTRUCTOR TRAINING:

The materials are designed to stand on their own. Orientation sessions for prospective presenters have been conducted, but no further sessions are planned at the present time.

MATERIALS:

Presenter's Manual	$ 9.75
Slides (set of 52)	$120.00

TITLE:

Black Parenting Education Program

CONTACT INFORMATION:

Dr. Calvin Lewis/Dr. Talmadge Williams
Relevant Educational Corporation, Inc.
4665 South 4th Street
Arlington, VA
(703) 920-7006

DESCRIPTION:

The Black Parenting Education Program (BPEP) is a competency based, comprehensive, culturally relevant parenting program designed to meet the unique needs of young, at-risk African American parents. BPEP was designed by African Americans to address issues of nurturing and raising children from an African American perspective. It is intended for all African American parents, including economically or educationally disadvantaged parents-at-risk who lack the skills, self-confidence, and motivation necessary to raise children successfully. BPEP helps to reduce or eliminate child abuse and developmental deficiencies by the use of age-appropriate stimulation activities and by creating a no-fail environment.

The mission of BPEP is to strengthen and empower African American families, teaching parents they have the power to raise children who are competent, confident individuals able to know, able to do, and, above all, able to think. "Success by Six" is the focus of this curriculum, which teaches young parents how to care for children aged 0-6, systematically preparing them for a successful school experience.

INSTRUCTOR QUALIFICATIONS:

This curriculum can be easily taught by persons with or without a background in training or child development. The trainer must love children and understand the stresses and problems facing young parents in today's society. He or she must be well-motivated to improve the conditions of development for young African American children and should be able to function as a group process facilitator, encouraging parents to discuss ideas and concerns.

INSTRUCTOR TRAINING:

Trainers attend a 1-day workshop, where they are taught to use the Success by Six training model—a variety of specially developed pedagogical techniques for teaching BPEP. The $795 fee includes a comprehensive training kit containing an Instructor's Manual, a videotape, and enough materials to conduct a 19-session workshop for a class of 12 parents. The fee also includes technical consultant assistance to assure effective implementation.

MATERIALS:

Trainers receive a kit with the following materials to conduct their own parenting workshops:

—A special Instructor's Manual for use during the workshop and as a step-by-step reference for teaching the program.

—An award-winning VHS videotape cassette—"Beautiful Black Children"—to communicate and demonstrate parenting skills.

—Twelve sets of Parent Manuals (five books per set) used by parents during their training and serving as a valuable reference long after training ends.

—Twelve sets of pretests and posttests for parents (five tests per set) to evaluate strengths and gauge what has been learned.

—A variety of training aids, e.g., attendance chart, letter of agreement, evaluation form, certificate of accomplishment.

TITLE:

Child Behavior Institute

CONTACT INFORMATION:

Robert G. Wahler, Ph.D.
Child Behavior Institute
215 Austin Peay Building
The University of Tennessee
Knoxville, TN 37996-0900

DESCRIPTION:

The Child Behavior Institute program is a therapeutic intervention developed for the treatment of antisocial and oppositional-aggressive child behavior in children 5 to 12 years old living in Knox County, Tennessee. Each family is assigned a therapist and seen once a week in family therapy. Parents and children participate in discussions, videotape presentations, role playing, and review of weekly home observations.

INSTRUCTOR QUALIFICATIONS:

The therapists are doctoral students in the clinical psychology training program at the University of Tennessee.

MATERIALS:

The Social Observation Coding Manual (SOC-III) and a Synthesis Teaching Coding Manual are used as teaching materials for observers who assess the treatment process.

TITLE:

Children and Home
YOU'VE GOT TO BE KID-DING!

CONTACT INFORMATION:

American Training Center, Inc.
2300 Central Avenue, Suite C
Boulder, CO 80301
(303) 442-5010

DESCRIPTION:

The Children and Home Program is part of the YOU'VE GOT TO BE KID-DING! series, released in the fall of 1985 in Boulder, Colorado.

Children and Home is not designed as a cure-all for everyone. It is not even an approach. Rather, it is the product of ideas, beliefs, and on-the-job training shared by people who have successfully raised capable young people.

The specific parenting skills taught in this program are verbal appreciation, feeling identification, problem ownership, problem resolution, modeling, consequence management, contracting, peer pressure resistance, verbal confrontation, therapeutic listening, problem assessment, family meetings, consultation, behavior specification, anger control, and family drug position skills.

Parents of preschool- through middle school-aged children from all socioeconomic and cultural groups are able to participate in this program. The crucial variable is to choose a facilitator who represents important aspects of the group.

INSTRUCTOR QUALIFICATIONS:

No specific educational credentials have been required of instructors, but most are educators, counselors, and social workers with master's degrees, good facilitation skills, and experience with the group process. Reportedly the formal educational qualifications are the least important. A person who is representative of and trusted and honored by the group, and who has good facilitation skills, is a likely candidate.

MATERIALS:

The program includes eight videotapes; a facilitator's manual, including activities that can be duplicated (such as role plays); situations to be discussed; overhead transparencies; and a participant's handbook. The entire program cost is $2,400.

EVALUATION FINDINGS:

No formal evaluations have been done, and at this writing only the pilot group reactions are available. The pilot groups were parents at a university laboratory elementary school and a mental health center. Both groups were heterogeneous, with many socioeconomic and educational levels and reasons for attending. The parents' motivation ranged from their own need to know to court-ordered attendance.

TITLE:

Confident Parenting: Survival Skill Training

CONTACT INFORMATION:

Kerby T. Alvy, Ph.D.
Center for the Improvement of Child Caring
11331 Ventura Boulevard, Suite 103
Studio City, CA 91604
(818) 980-0903

DESCRIPTION:

Initially designed for parents of children aged 2 through 12 who have behavior problems, the program has been used successfully with a variety of clinical populations as well as with religious and community parent groups whose children are not considered behaviorally disordered. It has been found helpful by a wide variety of parents of young children, including low- and high-income parents and ethnic minority parents.

The program teaches small groups of parents a variety of child management skills. The skills are directed toward increasing pro-social behaviors in children and decreasing problematic behaviors, i.e., disobedience, disruptiveness, fears, shyness, restlessness, aggressiveness, tantrums, laziness, and bedwetting. The overall intention is to facilitate a warm and loving climate in the home.

The parents are taught behavior specification and counting and charting skills so that they have standards against which child behavior increases or decreases can be judged. The child management skills taught are effective praise (a verbal appreciation skill), mild social disapproval (a verbal confrontation skill), systematic ignoring (an attention withdrawal skill), timeout from social reinforcement, and a detailed special incentive system to influence several behaviors at the same time. All of these skills are taught from a social learning perspective and are considered consequence management skills.

INSTRUCTOR QUALIFICATIONS:

A background in child development, group processes, and behavior modification is desirable.

INSTRUCTOR TRAINING:

A 3-day instructor training workshop for a minimum of 15 trainees is available at a cost of $350, which includes the instructor's training manual. Workshops can be conducted at any location in the United States or abroad, provided that the sponsoring group pays for the trainer's travel, per diem, and lodging expenses.

MATERIALS:

Instructor's manual with forms in English and Spanish	$45
Parents' Book	$7 (Spanish translation, $20)
Promotional flyers	$8 (per packet of 100)
Video demonstration tape of program skills	$25

TITLE:

The Effective Black Parenting Program

CONTACT INFORMATION:

Dr. Kerby T. Alvy
Center for the Improvement of Child Caring
11331 Ventura Boulevard, Suite 103
Studio City, CA 91604
(818) 980-0903

The Effective Black Parenting Program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970s that none of the widely used parent training programs in the United States was created specifically for African American parents.

This cognitive-behavioral program is intended to foster effective family communication, healthy African American identity, extended family values, child growth and development, and healthy self-esteem. It is also designed to play important prevention and treatment roles in community efforts to combat child abuse, alcohol and other drug use, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbance.

The program trains parents in rule development and skills in family meeting, problem assessment, behavior specification, consequence management, effective praise, systematic ignoring, timeout, and other parenting techniques. There are special instructional units on alcohol and other drug use prevention, pride in blackness, and single parenting.

The program consists of 14 3-hour training sessions and a 15th session for a graduation ceremony. Each training session includes an extensive review and role playing of skills taught in previous sessions. Optimal group size appears to be about 15 to 20 parents.

INSTRUCTOR QUALIFICATIONS:

A background in African American studies, African American parenting, parent education, child development, group processes, and behavior modification is desirable for instructors.

INSTRUCTOR TRAINING:

A 5-day instructor training workshop for a minimum of 15 trainees is available at a cost of $595 per trainee, which includes the Instructor's Manual. Workshops can be conducted at any location in the United States or abroad, providing that the sponsoring group pays for the travel, per diem, and lodging expenses of the CICC instructor.

Trainees receive provisional authorization to conduct the Effective Black Parenting Program and become certified after successfully running one program. After they have run additional programs, they become eligible for certification as an official trainer of trainers.

MATERIALS:

Instructor's Manual (582 pages)	$150
Instructional Charts $110 (transparencies)	$150 (slides)
Parent's Notebook (with 136 pages of enclosures)	$15
Program Graduate Reactions Video (14 minutes)	$15
Recruitment Flyers (packet of 100)	$8
Graduation Certificates (packet of 25)	$5

Supplementary Books:

Black Parenting: Strategies for Training	$19.95
Effective Black Parenting: A Review and Synthesis of Black Perspectives	$12.95
Parent Training: A Social Necessity	$14.95

TITLE:

Effective Parenting Information for Children (EPIC)

CONTACT INFORMATION:

Sandra Rifkin, President
EPIC
Executive Offices
State University College at Buffalo
1300 Elmwood Avenue
Cassety Hall - Room 319
Buffalo, NY 14222

DESCRIPTION:

EPIC is a cost-effective primary prevention program that joins together the home, the schools, and the community in an effort to give young people the skills to avoid problems such as alcohol and other drug use, school attrition, teenage pregnancy, and juvenile crime. The program is divided into three components: the school program, which provides inservice school staff training; the home program, which consists of support workshops for parents; and the community component, which unites community resources to meet local parenting needs.

INSTRUCTOR QUALIFICATIONS:

School program: A background in "affective" education, experience as a teacher, and interest in parent education and affective education are desirable. Two days of training are required.

Home program: A desire to help other parents and completion of the 2-day EPIC facilitator training (or 1-day child care training) are required. All instructors/facilitators should be comfortable in leading group discussions and committed to the goals of the EPIC program.

INSTRUCTOR TRAINING:

Schools program: Two types of teacher training are provided by certified EPIC trainers at a cost of $300/day per trainer. Generally, there will be two trainers for every 30 participants. Direct teacher training is a 6-hour program in which teachers learn new techniques to create the optimum learning environment for their students. Teachers participate in an experiential training model that introduces them to EPIC's three learning areas: Self Concept and Self Esteem; Rules, Rights, and Responsibilities; and Decision-Making/Problem Solving. A 2-day turnkey training program is also available, but direct training is recommended.

Home program: Certified EPIC trainers provide volunteer facilitators with 12 hours (2 days) of training in group dynamics and program content at a cost of $300/day per trainer. Child care providers receive 6 hours of training.

MATERIALS:

Schools program: Trainers receive a curriculum resource guide at $15 each.

Home program: Volunteer facilitators receive a facilitator's manual, at $10 each, and child care providers receive a child care manual, at $10 each. The cost of these manuals is covered by the replicator. Parent manuals are also provided at a cost of $10 each.

School program

EPIC *Growing Up Together* Curriculum Resource Guide	$15
EPIC-gram Quarterly Newsletter	Free of charge
EPIC Lessons-of-the-Month	Free of charge

Home program

Facilitator Manual (English or Spanish)	$15
Parent Manual (English or Spanish)	$10
Child Care Giver Manual	$10
Procedures Manual	$45

TITLE:

Epac Parent Training System

CONTACT INFORMATION:

Peoplescience, Inc.
P. O. Box 4232
Highland Park, NJ 08904
(800) 572-TEEN outside New Jersey
(201) 572-3120 within New Jersey

DESCRIPTION:

Program creator Fred Streit, Ed.D., found in the early 1970s that children's perceptions of their parents' behavior was a predictor of problem behavior, including alcohol and other drug use, running away from home, poor academic achievement, and sexual promiscuity. Recently, this original work was extended to examine the sources of parental expectations of children and children's perceptions of parental expectations.

This research led to the development of two professional manuals with which counselors, clinicians, and therapists could measure differences in such factors as parents' and children's perceptions of parental behavior, love, and caring; mutual expectations; children's expectations of a single parent; persuasive ability; and sensory dominance. Professionals who have used these Epac manuals, and consumers who have used the consumer-oriented Epac kits, requested a training program for parents.

The Epac Parent Training System is a parent information program that uses structured group dynamics. The system contains tests and exercises that parents can complete at home.

The program is intended for parents of preadolescents and early adolescents. It consists of six 2-hour sessions. The author recommends training groups of no more than 24 parents.

INSTRUCTOR QUALIFICATIONS:

The only qualification is previous experience in either leading a group or teaching. Leaders who have no interest in providing problem resolution for participants are preferred.

MATERIALS:

The Epac manual contains complete consumable materials for each session and separate facilitator instructions. One videotape is included as part of the first session.

TITLE:

Families in Touch Initiative Campaign

CONTACT INFORMATION:

Illinois Department of Alcoholism and Substance Abuse
Alvera Stern, Ed.D., Administrator
(312) 917-6332

DESCRIPTION:

The program emphasizes the development of skills in general parenting and issues specifically related to alcohol and other drug use. Training teams will be developed to conduct parent training sessions throughout the State. Central to the program's approach are the following concepts: parents are the most powerful influences on a child's life; parents are the preferred source of information on alcohol and other drug use; when parents and communities unite in educating the public about alcohol and other drugs, they have a profound influence on both individual use and societal attitudes.

TITLE:

Project Head Start

CONTACT INFORMATION:

U.S. Department of Health and Human Services
Office of Human Development Services
Administration for Children, Youth and Families
Head Start Bureau
Washington, DC 20201

DESCRIPTION:

The overall goal of the Head Start program is to bring about a greater degree of social competence in children of low-income families. Social competence takes into account the interrelatedness of cognitive and intellectual development, physical and mental health, nutritional needs, and other factors. Head Start objectives and performance standards provide for the improvement of the child's health and physical abilities; the encouragement of self-confidence, spontaneity, curiosity, and self-discipline; the enhancement of the child's conceptual and communication skills; the establishment of expectations of success; an increase in the child's and the family's ability to relate to each other; and the enhancement of a sense of dignity. Head Start provides opportunities for parent participation in program planning and operations, classroom activities, and parent-developed activities.

Experience has shown that the needs of children vary considerably from community to community and that, to serve these needs most effectively, programs should be individualized. Head Start permits and encourages local Head Start programs to develop variations on the standard Head Start model. The program options available are the standard Head Start model, variations in center attendance, double sessions, home-based models, and locally designed variations.

MATERIALS:

The *Head Start Exploring Parenting Curriculum* is a 20-session parent education group experience designed to help parents of Head Start children increase their parenting skills and to assist them in their roles as prime educators of their children. The curriculum includes sessions on normal growth and development, discipline, single parenting, stress, coping with a child's anger and fear, children's play, and understanding the child with special needs. The group experience accommodates up to 30 parents per session and is led by a member of the local Head Start staff who has received special training sponsored by Administration for Children, Youth and Families headquarters and regional offices. The curriculum is available in English and Spanish.

TITLE:

A Look at Adolescents
YOU'VE GOT TO BE KID-DING!

CONTACT INFORMATION:

American Training Center, Inc.
2300 Central Avenue, Suite C
Boulder, CO 80301
(303) 442-5010

DESCRIPTION:

A Look at Adolescents is one of three programs in the YOU'VE GOT TO BE KID-DING! series, released in 1985 in Boulder, Colorado.

An eclectic philosophy, based on the premise that positive discipline linked with real-world consequences enhances the dignity of both adults and children, pervades this program. Change, created through insight and successful experience in our relationships with adolescents, may increase our chances of raising capable, responsible, and independent children.

The specific parenting skills taught in this program are verbal appreciation, feeling identification, problem ownership, problem resolution, modeling, consequence management, contracting, peer pressure resistance, verbal confrontation, therapeutic listening, problem assessment, family meetings, consultation, behavior specification, anger control, and family drug position skills.

A Look at Adolescents is intended to be taught over 6 to 8 weeks for a minimum of 1½ hours per session. Group size has ranged from 6 to 50. Because the same videotape is used by every group, the information received by each group is fairly uniform, and the effects of having different presenters are limited.

Many ways of sharing information are used in the program, including lecture, demonstration, role playing, videotapes, outside reading, writing, and discussion of personal experiences.

INSTRUCTOR QUALIFICATIONS:

No specific educational credentials have been required of instructors, but most are educators, counselors, and social workers with master's degrees, good facilitation skills, and experience with the group process. Reportedly the formal educational qualifications are the least important. A person who is representative of and trusted and honored by the group, and who has good facilitation skills, is a likely candidate.

MATERIALS:

The program includes eight videotapes; a facilitator's manual, including activities that can be duplicated (such as role plays); situations to be discussed; overhead transparencies; and a participant's handbook. The entire program cost is $2,400.

TITLE:

Los Niños Bien Educados

CONTACT INFORMATION:

Dr. Kerby T. Alvy
Center for the Improvement of Child Caring
11331 Ventura Boulevard, Suite 103
Studio City, CA 91604
(818) 980-0903

DESCRIPTION:

The program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970s that none of the widely used parent training programs in the United States was created specifically for Hispanic parents.

This cognitive-behavioral program is intended to foster positive family communication, healthy Hispanic American identity, child growth and development, and healthy self-esteem. It is also designed to play important prevention and intervention roles in community efforts to combat child abuse, alcohol and other drug problems, juvenile delinquency, gang violence, learning disorders, and emotional disturbance.

It focuses on one of the dominant goals Hispanic parents often have in carrying out their parental functions—raising children to be well-educated (bien educados) in a social and personal sense as well as in an academic sense.

The training emphasizes skills in child management, effective praise, family meeting, problem assessment, timeout, increasing respectful behaviors, and other techniques.

Los Niños Bien Educados consists of 12 3-hour training sessions, the last of which serves as a review session and graduation ceremony. Optimal group size appears to be about 15 to 20 parents. A special instructional unit on alcohol and other drug use prevention is being developed.

INSTRUCTOR QUALIFICATIONS:

Bilingual, bicultural instructors are preferred, though bilingual instructors who are not Hispanic could teach the program. Backgrounds in Hispanic studies, child development, parent education, behavior modification, and group processes are desirable.

INSTRUCTOR TRAINING:

A 5-day instructor training workshop for a minimum of 15 trainees is available. The cost is $595 per person, which includes the Instructor's Manual. These workshops can be conducted at any location in the United States or abroad, providing that the sponsoring group pays for the travel, per diem, and lodging expenses of the trainer of trainers.

Trainees receive provisional authorization to conduct the Los Niños Bien Educados Program and become certified after successfully teaching one. After they have run the program, they become eligible for certification as trainers of trainers.

MATERIALS:

Instructor's Manual	$150
Instructional Transparencies	$110
Parental Expectation Cards	$50
Parents' Notebook	$15
Recruitment Flyers (packet of 100)	$8
Graduation Certificates (packet of 25)	$5

TITLE:

The Nurturing Programs

CONTACT INFORMATION:

Family Development Resources, Inc.
219 East Madison St.
Eau Claire, WI 54703
(715) 833-0904

DESCRIPTION:

The Nurturing series comprises four programs: The Nurturing Program for Parents and Children Birth to 5 Years, The Nurturing Program for Parents and Children 4 to 12 Years, The Nurturing Program for Parents and Adolescents, and The Nurturing Program for Teenage Parents and Their Families.

Parents and children learn new interaction patterns through reparenting. A strong experiential background increases the probability of the continued use of applied skills. The goal is acquisition and maintenance of appropriate parenting skills.

Each program consists of weekly sessions; sessions range in length from 45 minutes in the program for very young children to 2½ hours. Program lengths also vary. Each session has a specific focus and requires the use of skills acquired in earlier sessions.

INSTRUCTOR QUALIFICATIONS:

The Nurturing Programs are designed to be implemented by skillful professionals and paraprofessionals in social services, mental health, education, and other helping professions. Training in conducting home visits, group instruction, and working with infants, school aged children, or teenagers is required.

INSTRUCTOR TRAINING:

Workshops are available throughout the country. Workshops focus on presenting the nurturing philosophy of raising children, results of the field testing, and implementing and conducting the weekly sessions. Workshops are generally 2 days in length and cost approximately $200. The price includes manuals for the program and a workshop workbook.

MATERIALS:

The programs include a variety of instructional manuals, games, audiovisual presentations, dolls, coloring books, and other items.

TITLE:

Parent Effectiveness Training (P.E.T.)

CONTACT INFORMATION:

Effectiveness Training
531 Stevens Avenue
Solana Beach, CA 92075
(619) 481-8121

DESCRIPTION:

P.E.T. offers parents a skill-oriented course in communication, problem-solving conflict resolution, consulting, and environmental modification. Developed by psychologist Thomas Gordon, Ph.D., in 1962, it is intended as an economical alternative to psychotherapy for emotionally damaged children and dysfunctional families. P.E.T. teaches parents skills for creating a therapeutic family climate that fosters warm parent-child relationships, honest two-way communication, cooperation, consideration, and methods of rule setting and conflict resolution that produce solutions agreeable to everyone involved.

A P.E.T. training course is typically 24 hours in duration—8 weekly 3-hour sessions. Variations in this schedule may occur. Brief instructor presentations, group discussions, audiotapes, dyads for skill practice, workbook exercises, textbook reading assignments, and role playing are among the training methods used.

INSTRUCTOR QUALIFICATIONS:

Instructors are recruited through advertisements in newsletters and journals that address psychologists; social workers; parent educators; marriage, family, and child therapists; teachers; school counselors; and pastoral counselors. Trainees are authorized as P.E.T. instructors when they complete the training workshop, or one P.E.T. session, and receive positive evaluations from participants.

INSTRUCTOR TRAINING:

Instructor training workshops are 5½ days in length and cost $595 per person. The fee includes all instructor materials and one set of participant materials. Workshop size is limited to 30 participants; a minimum of 12 participants is required. Instructors receive a quarterly newsletter that provides ideas for instruction and marketing. Agencies can arrange workshops exclusively for their staff for $495 per person, with a minimum of 20 participants.

MATERIALS:

Participant materials include a 112-page workbook, a textbook, *P.E.T. in Action,* and *Manual on The Role of Parents in Drug and Alcohol Abuse Prevention.*

Instructor materials include the above and an instructor's guide, audiotape, book (*Getting Started*), wall charts, and role playing cards.

TITLE:

Parenting: The Underdeveloped Skill

A joint project of the National Congress of Parents and Teachers (National PTA) and the March of Dimes

CONTACT INFORMATION:

The National PTA
700 North Rush Street
Chicago, IL 60611-2571
(312) 787-0977

DESCRIPTION:

The National PTA offers a variety of information on and assistance in planning alcohol and other drug education activities. Informational brochures, resource lists, camera-ready advertisements, and other materials are available to help PTA leaders plan and conduct programs to prevent the use of alcohol, tobacco, and other drugs among children.

Parenting: The Underdeveloped Skill is a project designed to help PTA leaders conduct meetings and plan activities to improve parenting skills. It includes a leader's manual that provides objectives, meeting ideas, a core meeting activity, and background information for each session.

TITLE:

Parent to Parent

CONTACT INFORMATION:

The Passage Group
4675 N. Shallowford Road, Suite 200
Atlanta, GA 30338
(404) 451-9689

DESCRIPTION:

Parent to Parent is designed to provide parents of preteens and teens with the information and skills they need to help their children avoid alcohol and other drugs and guide them to adulthood. Participants learn to be more effective parents while giving their children room to develop into responsible individuals.

The program consists of three workshops presented in eight individual segments. The first workshop, The Me Within, presents fundamental concepts and facilitates an understanding of the causes and effects of adolescent alcohol and other drug use and the types of drug used. In the second workshop, parents learn six key steps in prevention. The third workshop, When All Else Fails, is the intervention phase of the program.

The program can be tailored to the needs of participants by the trained local facilitator. It is designed to be taught in small groups and encourages interaction.

MATERIALS:

Eight videotape training modules
Leader's guide
Student kits (workbooks and audiotapes)
Promotional newsletter

TITLE:

Parenting: Your Child from 1 to 6

CONTACT INFORMATION:

American Red Cross
Nursing and Health Services
1730 E Street, N.W.
Washington, DC 20006
(202) 727-8300

DESCRIPTION:

The course enables new parents to increase their ability to promote the health, safety, growth, and development of children; promote family health; and prevent child abuse and neglect. Parenting courses are organized by local Red Cross chapters. The curriculum was developed by Red Cross Nursing and Health Services at national headquarters in Washington, DC. Participants may be parents, people who work with children up to 6 years of age, adopting parents, grandparents, and high school and college students.

The course focuses on two primary roles of parents: the protective-nurturing role and the teaching-modeling role. The topics covered depend upon the needs and interests of the participants. They include children's sensorimotor, linguistic, intellectual, social, and emotional growth; discipline; safety; nutrition; and health. The discussions cover contemporary parenting philosophies and child development theories.

The course consists of eight 2-hour sessions. Recommended class size is 10 to 20 participants.

INSTRUCTOR QUALIFICATIONS:

The course is taught by authorized Red Cross parenting instructors. They include registered nurses, home economics or health teachers, health educators, social workers, psychologists, or others with special qualifications in child development and parenting.

MATERIALS:

Parenting—Parent's Workbook
Family Health and Home Nursing

TITLE:

Positive Indian Parenting: Honoring Our Children by Honoring Our Traditions

CONTACT INFORMATION:

Tery L. Cross, Director
The Northwest Indian Child Welfare Institute
Parry Center for Children
3415 S.E. Powell Blvd.
Portland, OR 97202

DESCRIPTION:

Positive Indian parenting nurtures, protects, guides, and teaches. For hundreds of years, Indian parents were guided by traditions that never left parenting to chance. Unfortunately, many of these traditions have declined in Indian families because of the influence of the dominant society. The Positive Indian Parenting curriculum is a brief, practical, culturally specific training program whose first goal is to help Indian parents explore and apply the values and attitudes expressed in historical Indian child-rearing practices. The curriculum's second goal is to help parents develop positive and satisfying attitudes, values, and skills that have roots in Indian cultural heritage.

Because there is no one child-rearing tradition among Indian people, the curriculum draws examples from numerous tribes. Each individual using the program must tailor it to fit his or her culture. There are, however, some universal values, attributes, and customs on which the trainer can build: the oral tradition, story telling, the spiritual nature of child rearing, and the role of the extended family.

The curriculum consists of eight sessions, each with specific learning objectives. Each session is designed to take two to three hours. It is suggested that each session end with social time. The trainers' manual includes a bibliography.

TITLE:

Preparing for the Drug (Free) Years

CONTACT INFORMATION:

Developmental Research and Programs
P. O. Box 85746
Seattle, WA 98145
(206) 781-0707

DESCRIPTION:

Developed by Dr. J. David Hawkins and Dr. Richard F. Catalano of the University of Washington in conjunction with Developmental Research and Programs, preparing for the Drug (Free) Years is a skill-based program presented in five workshops that empower parents to reduce the risk that their children will develop alcohol or other drug problems while strengthening family bonds.

The risk factors addressed are parental drug use and positive parental attitudes toward alcohol and other drug use, friends who use alcohol and other drugs, family management problems, poor bonding to the family, and early first use of alcohol or other drugs.

The five workshops are "Getting Started: How to Prevent Drug Abuse in Your Family," "Setting Guidelines: How to Develop a Family Position on Drugs," "Avoiding Trouble: How to Say No to Drugs," "Managing Conflict: How to Express and Control Your Anger," and "Involving Everyone: How to Strengthen Family Bonds."

INSTRUCTOR QUALIFICATIONS:

Preparing for the Drug (Free) Years is designed to be led by two persons. Both leaders should have good verbal skills, and at least one leader should be a parent. Prior experience in teaching or group facilitation is also helpful.

INSTRUCTOR TRAINING:

A 3-day leader's training course prepares educators, medical professionals, employee assistance personnel, human services workers, social workers, psychologists, PTSA leaders, clergy and church group leaders, and civic leaders to conduct the parent workshops. The fee for an onsite training session is $6,800 plus travel and expenses for instructor. Up to 52 leaders can be trained per session. The fee for attending one of the quarterly sessions in Seattle is $275 per leader and includes the Family Activity Book, Workshop Leaders' Guide, and Training Workbook.

MATERIALS:

The curriculum kit contains all materials needed for 5 parent training workshops: 35 family activity books, 2 workshop leaders' guides, 5 videotapes, a set of transparencies, and a set of transparency masters for handouts. The kit costs $1,095.

Discounts are available on quantities of 50 or more.

TITLE:

Systematic Training for Effective Parenting (STEP)

CONTACT INFORMATION:

American Guidance Service
Publisher's Building
Circle Pines, MN 55014
(800) 328-2560

DESCRIPTION:

STEP is a nine-session program designed to teach parents a method of raising responsible, confident children. The topics addressed include understanding children's behavior and misbehavior, encouragement, listening, exploring alternatives and expressing ideas and feelings, developing responsibility (discipline), decisionmaking, the family meeting, and developing confidence and using your potential.

Each session is 2 to 2½ hours long. Sessions provide parents with the opportunity to share their concerns and receive feedback and encouragement from others.

INSTRUCTOR QUALIFICATIONS:

The leader's job is to get members involved with the materials and with each other. An effective leader acts as a facilitator rather than as an expert, thereby modeling the democratic process. Skills in structuring discussions, soliciting involvement from all participants, promoting feedback, and other facilitation techniques are desirable.

INSTRUCTOR TRAINING:

Contact Gary McKay, Ph.D., 1800 N. Heathrae Avenue, Tucson, AZ 85715, (602) 885-8197, for information on training of group leaders.

MATERIALS:

The STEP kit includes a Leader's Manual, a Parent's Handbook, five audiocassettes or a videotape, charts, a discussion guidelines poster, publicity aids, and a sample certificate of participation (additional certificates can be ordered).

TITLE:

Systematic Training for Effective Parenting of Teens (STEP/Teen)

CONTACT INFORMATION:

American Guidance Service
Publisher's Building
Circle Pines, MN 55014
(800) 328-2560

DESCRIPTION:

A multimedia, Adlerian program for improving parent-teen relationships, STEP/Teen is based on the parenting program STEP, which is used worldwide. STEP/Teen also integrates communication skills and Rational Emotive Therapy with the basic Adlerian approach. In STEP/Teen, parents learn a systematic approach to resolving challenges. They have an opportunity to share their concerns and to receive feedback and encouragement from other parents.

The program makes the following theoretical assumptions: Humans are social beings whose main goal is to belong. Behavior and misbehavior are seen as purposeful and goal directed—as means to achieve belonging. When children and teenagers believe that they cannot achieve belonging in useful ways, they become discouraged; misbehavior is often the result of this discouragement.

LEADER QUALIFICATIONS:

The leader's job is to get members involved with the materials and with each other. An effective leader functions as a facilitator rather than as an expert and thereby models the democratic process. A good leader is able to structure the discussion, identify common themes in members' comments, solicit participation from all members, put into action ideas generated at previous meetings, promote direct interaction among group members, and provide encouragement.

LEADER TRAINING:

Contact Gary McKay, Ph.D., 1800 N. Heathrae Avenue, Tucson, AZ 85715, (602) 885-8197, for information about training of trainers.

TITLE:

The Next STEP

CONTACT INFORMATION:

American Guidance Service
Publisher's Building
Circle Pines, MN 55014
(800) 328-2560

DESCRIPTION:

The Next STEP is a followup program to STEP and STEP/Teen. It provides parents who have completed these programs the opportunity to apply the parenting skills they have developed and to acquire new skills.

Participants share their successes and challenges and obtain encouragement from the group. The session topics include "taking a fresh look at your parenting," "building self-esteem," "how lifestyle beliefs affect your parenting," and "gentle strength and firm love."

The format of the program is flexible. The group can decide to spend one session on each of the six topics, select certain topics from the list, or devote more than one session to a particular topic. Adaptations for single parents, stepparent families, and parents of young children are included where appropriate. The Problem Solving Group, an advanced technique not included in STEP or STEP/Teen, allows parents to develop specific plans for resolving parent-child conflicts.

INSTRUCTOR QUALIFICATIONS:

An effective leader has skills that facilitate group interaction and that model the democratic process.

INSTRUCTOR TRAINING:

For information on training of group leaders, contact Gary McKay, Ph.D., 1800 N. Heathrae Avenue, Tuscon, AZ 85715, 602/885-8197.

MATERIALS:

The Next STEP kit costs $99.50 and consists of a Leader's Guide, audiocassettes, the parent's handbook entitled *The Effective Parent,* exercises, an explanation of the Problem Solving Group, and discussion guide posters.

TITLE:

New Beginnings (A STEP Program)

CONTACT INFORMATION:

Research Press
P. O. Box 3177
Department H
Champaign, IL 61821
(217) 352-3273

In Canada:
Research Press of Canada
123 Bridgeport Road East
Waterloo, Ontario
N2J 2K3
Canada

DESCRIPTION:

New Beginnings is a multimedia, Adlerian-based program addressing the skills needed by single parents and step-family parents. It is designed to be used with a group of single parents, step-family parents, or both.

These families can learn from each other to face issues such as loss and grief, dealing with ex-spouses and former in-laws, custody, and community prejudice. Parents learn to deal with child-raising challenges unique to their family structures as well as those that can occur in any family.

Sessions are 2 hours long. The topics covered include self-esteem, relationships and behavior, personality and emotional development, communication skills, decisionmaking, discipline, and personal and family challenges.

MATERIALS:

New Beginnings Kit	$65
Extra Parents' Manuals, 1-9 copies	$9.95
10 or more	$8.95
New Beginnings Video	$240

TITLE:

The Strengthening Families Program

CONTACT INFORMATION:

Karol L. Kumpfer, Ph.D.
Social Research Institute
Graduate School of Social Work
University of Utah
Salt Lake City, UT 84112

DESCRIPTION:

The Strengthening Families Program began as a research project funded through the National Institute on Drug Abuse (NIDA). One of the objectives of the study was to develop, implement, and evaluate three prevention interventions: the Parent Training Program, the Children's Skills Training Program, and the Family Life Skills Training Program.

The Parent Training Program is intended for parents who are currently in treatment and have children aged 6 through 12 living at home. The parents learn to identify problem behavior, ignore inappropriate behavior, and reward and increase appropriate behavior.

The Family Life Skills Program involves both parents and children. At least one parent in each family is enrolled in an alcohol and other drug abuse treatment facility. The program develops skills in verbal appreciation, feeling identification, therapeutic listening, problem assessment, problem resolution, environmental modification, rule development, consequence management, timeout, and other techniques.

The Parent Training Program is presented in 14 consecutive 30-minute sessions. The Family Life Skills Training Program is presented in 14 consecutive 2-hour weekly sessions.

INSTRUCTOR QUALIFICATIONS:

There are no minimum qualifications. Selection is based on the requirements of target populations.

INSTRUCTOR TRAINING:

Instructor training requires at least 3 days. There is no minimum enrollment. A maximum enrollment of 12 persons is recommended. The cost of training and program materials is negotiated on an individual basis.

TITLE:

Talking With Your Kids About Alcohol (TWYKAA)

CONTACT INFORMATION:

The Prevention Research Institute
629 North Broadway, Suite 210
Lexington, KY 40508
(606) 254-9489

DESCRIPTION:

TWYKAA is a primary prevention program for parents of children of any age. It is intended for parents whose children are not chemically dependent. The program recognizes that young people are faced with social pressures to use alcohol and that parents are in an excellent position to strongly influence their children to abstain. The program is designed to help parents prepare their children to make age-appropriate responses during adolescence and later in life. Parents learn to give their children information for a lifetime of age-appropriate decisions consistent with family expectations and values.

TWYKAA seeks to reduce the risk of alcohol-related problems among either parents or children by increasing abstinence and delaying the onset of use.

TWYKAA is presented in four sessions. The first two sessions teach parents *what* to say to their children; the third and fourth sessions teach parents *how* to say it.

The companion program, Talking With Your Students About Alcohol, is available to schools in communities where TWYKAA is available to parents.

INSTRUCTOR TRAINING:

Instructor training is provided by the Prevention Research Institute at approximately $315 per person, which includes the instructor's manual.

Chapter 7:
Implementing A Parenting Program In Your Community

David Pines, M.Ed.

The steps for implementing a community parenting program depend on what is in place in the community already. A needs assessment and resources inventory should be conducted to obtain this information, after which the implementation process can begin. The first three stages of a program are preparation, implementation, and followup.

PHASE I: PREPARATION

TASK FORCE

Initially, an individual or group of individuals should undertake to bring training into the community. This could be a community task force, an agency of the local government, a group from a religious organization, a parent/student/teacher association (PSTA), a school/community group, a civic organization, or an employee assistance program from a company or a consortium of companies. The person who convenes the initial meeting must be recognizable in the community and have the ability to assemble and lead a group of powerful people.

PURPOSE

The purpose of this initial meeting should be to explore the possibility of parent training in the community as a way to help prevent alcohol and other drug use. It is important that everyone be aware of the entire training and development process in the beginning, so that individuals can make informed choices about committing their time and energy to the project. If the group is willing to bring parent training into the community, and people commit their time to the project at least until predetermined results are achieved, the project can progress. If the group is not willing, someone on the task force will have to find people who are ready and willing to commit to making the project a success.

MEETING SCHEDULES AND AGENDA

As with any group project, it is imperative that a calendar be determined at the outset (it can be modified at a later date). It is generally useful to hold meetings at a regularly specified time (e.g., the first Tuesday of each month for a 90-minute breakfast meeting, or the second Thursday of each month at 2:00 p.m.). It should be recognized that some members may not be able to attend every session.

Each meeting should have a purpose and an agenda that keeps the meeting moving toward a conclusion. The agenda should include a report from each committee.

ROLES AND RESPONSIBILITIES

Mission. The mission of the project sustains enthusiasm and dedication. Every person on a task force has a job that is crucial to the accomplishment of the mission. The first job of the task force is to determine its mission statement. This statement usually is general in scope and is not restricted by time (e.g., "the mission of the Community Parent Project is to provide ongoing training for parents in order to enable them to have healthy and nurturing families and prevent alcohol and other drug use problems"). Once the mission is established, it is easy to generate goals and objectives that support it.

Goals. Goals are the broad statements that support the intended outcome of the project (e.g., "one goal of the Community Parent Project is to bring requested training to three neighborhoods in 1990").

Objectives. An objective is a readily achievable milestone with a specific measurable outcome that occurs in an agreed-upon timeframe (e.g., "the Community Parent Project will conduct a community needs assessment with 15 government agencies, 30 private agencies, and 200 community residents by May 15, 1991").

OFFICERS

Each member of the task force should be able to make an active contribution to the group. An organizational structure can involve chairpeople, recorders, and a treasurer. Some other structure may be devised. It is recommended that the group keep accurate records and meeting notes for future reference. There are quite a few models for successful task force implementation.

PLANNING

Planning is the one aspect of community project implementation that will save time, energy, and frustration. Whether or not a plan is constantly followed, it is as necessary as a road map in getting from place to place. If unanticipated problems necessitate a detour, at least there is a plan to deviate from.

LENGTH OF PROJECT

From the outset, it is important that the task force have a completion time for the project. At that time it will be necessary to determine whether there is sufficient commitment to go further.

TARGETED POPULATION FOR TRAINING

The targeted population can be any group or organization specified by the needs assessment. This may begin as a small group (the parents of a single class in an elementary school), or a large group (all of the employees in a corporation who have children between 2 and 15 years of age). No matter where the project begins, it is important to realize that it can and should grow. Growth comes from planning and nurturing.

END RESULT WANTED IN THE COMMUNITY

Vital to the project is the knowledge of the end result. "End result" refers to whatever achievements are desired in the community at the end of the project. Results should be stated as goals (measured outcomes) with specific objectives for support (interim outcomes that occur in a timeframe and point to the achievement of the goal).

DETERMINATION OF THE TARGET COMMUNITY

The community must be defined. "Community" might refer to all of the people in an area, the parents in a specific school district, a political district, the members of an organization, the employees of a company, the viewers in a media market, or some other political, social, or geographic demography.

DETERMINATION OF COMMUNITY NEEDS (COMMUNITY NEEDS ASSESSMENT)

There are many ways to assess the needs of the community. Although a great many surveys are available through such places as the National Clearinghouse for Alcohol and Drug Information, it is important to fit the questions to the specific community.

When targeting a population to poll, be sure to take into account the variety of systems, agencies, and organizations that deal with parents in that community. Some examples:

- Community action agencies
- Parent/student/teacher associations

- Community mental health centers
- Social service agencies
- Fraternal or societal organizations
- Religious institutions

Be sure to have a sample of the community that is representative of as many of the people as possible. The timeframe and number of respondents must be specified at the start of the process. Assessing needs can be an annual part of the community prevention plan.

RESPONSE TO THE RESULTS OF THE SURVEY

Once the questions have been asked, the results should be tabulated and acted upon. If, for example, 75 percent of the respondents indicate that they do not think there is a need for parent training at this time, the task force should honor that response. On the other hand, if 51 percent feel that parent training would support good family relationships, and 62 percent feel that good family relationships are a major factor in decreasing the risk of alcohol and other drug use by family members, the task force probably should consider a pilot project with a good evaluation component. On the basis of this project, the task force can decide whether to go further in implementing parent training.

IDENTIFICATION OF APPROPRIATE PROGRAMS

From the programs listed in this guide to the programs developed by local community groups, the range and depth of parent training programs is enormous. There probably is a specific program that will address the needs of any community. Finding the right program will take work, and the task force should establish a subcommittee to handle this investigation and selection. The program descriptions in this manual will help.

DETERMINATION OF THE RESOURCES AVAILABLE FOR IMPLEMENTATION

Whatever the services, it is important that they be available at the least possible financial burden to the recipients. It is incumbent upon the task force to address implementation at little or no cost to the target community. Many people have money to spend on courses that improve the quality of their lives, but many more do not. To a large segment of the population, programs and courses seem frivolous. There may be no economic incentive apparent in attending a program for effective parenting. For many people, even though family life is not working out the way they expected, it can be threatening to be invited to participate in a program about being a more effective parent (which some individuals may see as an implication that they are not good parents).

Participation in a program may even add to family expenses because of the cost of babysitting, gasoline, parking, and so forth. These are important considerations in determining the real costs of workshops to participants. There are many ways to subsidize people who want to take advantage of the programs being offered.

LOCAL FUNDING SOURCES

In many communities, small grants and other public funds are available for alcohol and other drug prevention programs such as parent training. It is always important to have as much support as possible from elected officials when accessing these funds. Local corporations and businesses are sources of private funding. It is always wise to point out the advantages of corporate investments in community projects. When corporations invest in alcohol and other drug prevention, they are investing in the future of their community and their clientele. Make sure the contributors of funds are fully acknowledged.

STATE FUNDING SOURCES

Every State has agencies that support endeavors to improve the quality of life for people in the community. To determine the appropriate place to begin to look for funding, a local task force should address the State representative by letter, then send him or her an invitation to a meeting. Having allies in the State legislature is very beneficial. It is particularly impressive if the community group can demonstrate an ability to have local investors participate in cost sharing.

NATIONAL FUNDING SOURCES

The Federal Government supports many demonstration programs through grants and contracts. Some of the most prominent people in the country are available as consultants through Federal technical assistance programs. These programs can be accessed through inquiries to congressional representatives or cabinet members in the executive branch, and direct requests to specific agencies, or Federal offices. It is easy to locate Federal assistance through State and local offices. The resource guide in the Appendix tells whom to contact in your State.

PHASE II: IMPLEMENTATION

Once the task force has established a plan of action, the next phase is bringing that plan into the community.

CONTACT THE PROGRAM DEVELOPERS AND CONTRACT FOR IMPLEMENTATION

Although the programs presented in chapter 6 are not exhaustive of the field of effective parenting, they are generally accepted as the leading programs in the field. A wide range of programs is available. In many instances, programs are available through school systems, adult education classes, local free universities, or other community agencies. Contacting the program developers directly can accelerate the implementation process.

If an agreement is reached orally, it is necessary to formalize what has been agreed upon through a written contract for services. The task force should have a legal representative who will assume this responsibility.

DETERMINE THE SCHEDULE

Once the program has been selected and the contract for services developed, the task force may have to redefine the timeframe for implementation of the project.

PUBLICIZE THE EFFORT

When all of the times, dates, and locations are established, it is vital to get the word out. People must enroll and, in order to enroll, they must know about the program. This is the time to use the media and publicity connections of task force members. Publicity often is overlooked but must be included if any endeavor is to be successful. Many advertising agencies will support public service campaigns by providing free services. It is worthwhile to investigate.

ENROLL PEOPLE IN THE PROGRAM

Programs are most effective when the participants are fully engaged. When enrolling people in the program, it is important to let them know what they can expect from participation. Every program has brochures and handouts, but these do not enroll people. Participation must have a direct and verifiable benefit that outweighs the time and money invested in participating, particularly in populations for whom the cost (financial and otherwise) is high.

Many people are unlikely to participate in activities that will not put food on their tables or clothes on the backs of their children. These are the people who must be convinced of tangible, long-term benefits. Points to make in encouraging participation include the following:

- Families who support each other are less likely to have problems with alcohol and other drugs.

- If alcohol and other drug problems arise, parents who are trained in communication and empowerment are more likely to resolve the problems quickly and effectively.
- Strengthening families increases the likelihood of children completing school.
- Effective parenting skills are natural, and there is no way to fail in the program.
- Supportive, nurturing home environments are more likely to generate working people.
- There is nothing wrong with learning how to be a more effective parent.
- It does not take much to be an ineffective parent, but it takes commitment to be an effective parent.

Enrollment requires a commitment from both the person being enrolled and the people doing the enrolling. Have some community introductions to the workshop. Set a target for the number of people to have there. Ask people to invite their friends and acquaintances. Serve refreshments. Have skilled people speak about the workshop and have a way for people to sign up. Remember that babysitting fees and other costs of attending can be a hardship, particularly for single parents. Consider having someone at the workshop site to provide child care during the sessions (a job opportunity for a teenager). Design the series of workshops in a way that supports and empowers the participants. If this tone is set at the first session, a trust is built that is hard to destroy. If the first session is difficult or uninspiring, do not expect parents to return.

HANDLE THE LOGISTICS OF THE PROGRAM

Make sure that the workshop location is central and accessible. It is useful to have several volunteers greet and make name tags for participants and set up the chairs and tables in the room. Have the "classroom" look inviting.

PHASE III: ENSURING SUCCESS

PROVIDING FOLLOWUP OPPORTUNITIES

People leave a workshop with new enthusiasm and possibilities for action. These possibilities will diminish without support and followup. In many situations, the task force is the advocate for followup activities, including evaluation and technical assistance, but the real support comes from community organizations.

Following parent training, there must be continued communication with people who have just begun to deal with the issue of creating a nurturing environment in which to raise their children. Many of the usual avenues for adult-to-adult relationships do not address the issues brought up in these training workshops. It is often useful to create a subgroup within a local organization. This group may start small, but grow as more workshops are offered and more people complete the courses. The membership of these subgroups will change as members' children grow older and their family situations shift. There must be a built-in longevity so that when the first generation of participants has graduated, the programs continue.

PROGRAM EVALUATION

The word that most community people hate to hear, but know they need to, is evaluation. One of the most reliable and inexpensive means of demonstrating the difference a program makes in the community is to use local university students to evaluate a program. It is beneficial for the task force to create a relationship with a local university. The school provides graduate students to prepare preliminary information on the community, process evaluation of the trainings and evaluation of the immediate impact of the program on the lives of the participants and the community, and perhaps even conduct impact evaluation to determine the effects of the program over an extended time period.

REPORTING RESULTS

It is good practice to keep records of the work accomplished. These records can be used to generate reports to those who have supported the program. The kinds of information in which many organizations and agencies are interested varies, so it is advisable to ask in the beginning what a final report should include. Data can be collected to fill that need. At minimum, statistics should be kept on the number of people who began the program, the number who completed the program, and meeting attendance. People may be interested in instances of reported family violence and whether the rates are affected by the program. It would be very beneficial to record statistics about alcohol and other drug use (driving under the influence, drug- related crime, youth use surveys, etc.), as well as statistics on the related issues of teen pregnancy, suicide, school dropouts, and other affected areas.

PUBLICITY

Let everyone know what is going on. Issue reports on the work that people have done and its results. The media play a vital role in today's society. The more they are involved in delivering a positive message to our communities, the closer our communities come to being a nurturing environment for families and youth.

About the Authors

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Dr. Alvy is a clinical psychologist and the founder and Executive Director of the Center for the Improvement of Child Caring. During more than a decade of work in the mental health community in Los Angeles, he has developed the Effective Black Parenting Program, the Los Niños Bien Educados Program, and the Confident Parenting Program.

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Ms. Houghton is the author of several books on parental organization and involvement in creating drugfree communities. She is a national spokesperson for the parent and community role in drug prevention and intervention.

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Dr. Stern is the former director of the Prevention Division of the Department of Substance Abuse for the State of Illinois. She has been the President of the National Prevention Network and remains on its executive committee. She has been instrumental in the development of the InTouch Program Series for the State of Illinois.

Appendix A

Appendix A is a list of potential intermediary organizations—groups concerned with alcohol and other drugs, families and children, and specific audiences—that may be interested in alcohol and other drug problem prevention programs. Although extensive, this list is by no means exhaustive. The organizations included are a *sample* of the many local, regional, and national organizations that could be included in alcohol and other drug programs. The listing is divided into the following sections: 1) organizations focusing primarily on alcohol and other drugs and 2) organizations concerned with families and children.

ORGANIZATIONS FOCUSING PRIMARILY ON ALCOHOL AND OTHER DRUGS*

*Organizations listed here only as example; inclusion does not imply endorsement by OSAP.

ACTION Drug Alliance
Room M-513
806 Connecticut Avenue, NW
Washington, DC 20525
(202) 634-9759

Alateen, Al-Anon Family Group
Headquarters, Inc.
P.O. Box 862, Midtown Station
New York, NY 10018-0862
(800) 356-9996

Alcohol and Drug Problems
Association of North America
444 N. Capitol Street, NW, Suite 181
Washington, DC 20001
(202) 737-4340

Alcoholics Anonymous
P.O. Box 459
Grand Central Station
New York, NY 10163
(212) 686-1100

Al-Anon Family Group Headquarters
1372 Broadway
New York, NY 10018
(212) 302-7240

American Council for Drug Education
204 Monroe Street, Suite 110
Rockville, MD 20850
(301) 294-0600

Association of Medical Education and
Research in Substance Abuse
c/o David C. Lewis, M.D.
Center for Alcohol and
Addiction Studies
Brown University
Providence, RI 02912
(401) 863-1102

Association of the Halfway House
Alcoholism Programs of
North America
786 E. Seventh Street
St. Paul, MN 55106
(612) 771-0933

The Chemical People
WQED
4802 Fifth Avenue
Pittsburgh, PA 15213
(412) 622-1491

Children of Alcoholics Foundation
P.O. Box 4185, Department N.A.
Grand Central Station
New York, NY 10163
(212) 351-2680

Committees of Correspondence
57 Conant Street, Room 113
Danvers, MA 01923
(617) 774-5626

Cottage Program International
736 South 500 East
Salt Lake City, UT 84102
(801) 532-6185

Elks Drug Awareness Program
P.O. Box 310
Ashland, OK 97520
(503) 482-3193

Employee Assistance Professional
Association (formerly ALMACA)
1800 N. Kent Street, Suite 907
Arlington, VA 22209
(703) 522-6272

Families Anonymous
14553 Delano Street, #316
Van Nuys, CA 91411
(818) 989-7841

Families in Action
National Drug Information Center
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30045
(404) 934-6364

Hazelden Foundation
15245 Pleasant Valley Road
Center City, MN 55012
(612) 257-4010

Impaired Physician Program
1669 Phoenix Parkway, #102
Atlanta, GA 30349
(800) 445-4232

Institute of Alcoholism
and Drug Dependency
Andrews University
Berrien Springs, MI 49104
(616) 471-3558

Institute on Black Chemical Abuse
2614 Nicollet Avenue
Minneapolis, MN 55408
(612) 871-7878

International Commission for the
Prevention of Alcoholism
and Drug Dependency
6840 Eastern Avenue, NW
Washington, DC 20012
(202) 722-6729

Just Say No Clubs
1777 N. California Boulevard
Walnut Creek, CA 94596
(800) 258-2766

Mothers Against Drunk Driving
(MADD)
669 Airport Freeway, Suite 310
Hurst, TX 76053
(817) 268-6233

Multi-Cultural Substance Abuse
Prevention Project
Karen Johnson Associates
1110 Bonifant Street, Suite 300
Silver Spring, MD 20910
(301) 589-4555/(800) 822-0047

Narcotics Anonymous
P.O. Box 9999
Van Nuys, CA 91409
(818) 780-3951

Narcotics Education, Inc.
6830 Laurel Street, NW
Washington, DC 20012
(202) 722-6740

National Association of Alcoholism
and Drug Abuse Counselors, Inc.
51 South George Mason Drive
Arlington, VA 22204
(703) 920-4644

National Association of Alcoholism
Treatment Programs
2082 Michelson Drive, Suite 101
Irvine, CA 92715
(714) 476-8204

National Asian Pacific American
Families Against Substance Abuse
6303 Friendship Court
Bethesda, MD 20817
(301) 530-0945

National Association for Children
of Alcoholics
31582 Coast Highway, Suite B
South Laguna, CA 92677
(714) 499-3889

National Association for Native
American Children of Alcoholics
c/o Seattle Indian Health Board
P.O. Box 3364
Seattle, WA 98114
(206) 324-9360

National Association of Lesbian/Gay
Alcoholism Professionals
204 W. 20th Street
New York, NY 10011
(617) 738-5146

National Association of State Alcohol
and Drug Abuse Directors
444 N. Capitol Street, NW, Suite 530
Washington, DC 20001
(202) 783-6868

National Black Alcoholism
Council, Inc.
417 S. Dearborn Street, Suite 100
Chicago, IL 60605
(312) 663-5780

National Clearinghouse for Alcohol
and Drug Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

National Clergy Council on
Alcoholism and Related Drug
Problems
1200 Varbyn Street, NE
Washington, DC 20017
(202) 832-3811

National Council on Alcoholism
12 W. 21st Street
New York, NY 10010
(212) 206-6770/(800) NCA-CALL

National Episcopal Coalition on Alcohol and Drugs
P.O. Box 10184
Washington, DC 20018
(202) 543-1166

National Federation of Parents for Drug-Free Youth
Communication Center
1423 N. Jefferson
Springfield, MO 65802
(417) 836-3703

National Hispanic Families Against Drug Abuse
1511 K Street, NW, Suite 1026
Washington, DC 20005
(202) 393-5136

National Organization of Student Assistance Programs and Professionals
250 Arapahoe, Suite 301
Boulder, CO 80302
(303) 449-8077

National Parent's Resource Institute for Drug Education
100 Edgewood Avenue, Suite 1216
Atlanta, GA 30303
(800) 241-7946

National Prevention Network
444 N. Capitol Street, NW, Suite 530
Washington, DC 20001
(202) 783-6868

Phoenix House Foundation
164 W. 74th Street
New York, NY 10023
(212) 595-5810

Potsmokers Anonymous
316 E. Third Street
New York, NY 10009
(212) 254-1777

Research Society on Alcoholism, Inc.
4314 Medical Parkway, Suite 300
Austin, TX 78756
(512) 454-0022

Substance Abuse Librarians and Information Specialists (SALIS)
c/o Project CORK—Resource Center
Dartmouth Medical School
Hanover, NH 03756
(603) 646-7540

TARGET—Helping Students Cope with Alcohol and Drugs
11724 Plaza Circle
Kansas City, MO 64195
(816) 891-7442

The Other Victims of Alcoholism
P.O. Box 921, Radio City Station
New York, NY 10101
(212) 247-8087

Therapeutic Communities of America
131 Wayland Avenue
Providence, RI 02906
(401) 331-4250

TOUGHLOVE International
P.O. Box 1069
Doylestown, PA 18901
(215) 348-7090

Women for Sobriety
109 W. Broad Street
P.O. Box 618
Quakertown, PA 18951
(215) 536-8026

ORGANIZATIONS CONCERNED WITH FAMILIES AND CHILDREN*

*Organizations are listed here only as examples; inclusion does not imply endorsement by OSAP.

Adoption Triangle Ministries
Box 1860
Cape Coral, FL 33910
(813) 542-1342

Allied Youth International
1901 Fort Myer Drive, Suite 1011
Arlington, VA 22209

American Association for Marriage
and Family Therapy
1717 K Street, NW, Suite 407
Washington, DC 20036
(202) 429-1825

American Association for Counseling
and Development
5999 Stevenson Avenue
Alexandria, VA 22304
(703) 823-9800

American Association for
Protecting Children
c/o American Humane Association
9725 E. Hampton Avenue
Denver, CO 80231
(303) 695-0811

American Association for
Suicidology
2459 South Ash
Denver, CO 80222
(303) 692-0985

American Home Economics
Association
2010 Massachusetts Avenue, NW
Washington, DC 20036
(202) 862-8300

American Justice Institute
705 Merchant Street
Sacramento, CA 95814
(916) 442-0707

American Values: The Community
Action Network
211 E. 43rd Street, Suite 1400
New York, NY 10017
(212) 818-1360

Associates for Troubled Children
19730 Ventura Boulevard, Suite 1A
Woodland Hills, CA 91364
(818) 713-0086

Association for Children and Adults
with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234
(412) 341-1515

Association of Community
Organizations for Reform Now
401 Howard Avenue
New Orleans, LA 70130
(504) 523-1691

Better Boys Foundation
407 S. Dearborn, Suite 1725
Chicago, IL 60605
(312) 427-4434

Big Brothers/Big Sisters of America
230 N. 13th Street
Philadelphia, PA 19107
(215) 567-7000

Boys Clubs of America
National Prevention Program
771 First Avenue
New York, NY 10017
(212) 351-5900

Boys Scouts of America
1325 Walnut Hill Lane
Irving, TX 75038
(214) 580-2000

Breakthrough Foundation
25 Van Ness Avenue, Suite 320
San Francisco, CA 94102
(415) 863-4141

Call for Action
575 Lexington Avenue, 7th Floor
New York, NY 10022
(212) 355-5965

Catholic Big Brothers
1011 First Avenue
New York, NY 10022
(212) 371-1000

Center for Organizational and
Community Development
School of Education, Room 225
University of Massachusetts
Amherst, MA 01003
(413) 545-2038

Center for the Improvement
of Child Caring
11331 Ventura Boulevard, Suite 103
Studio City, CA 91604
(818) 980-0903

Center on Human Policy
724 Comstock Avenue
Syracuse, NY 13244
(315) 443-3851

Child Welfare League of America
440 First Street, NW
Washington, DC 20001
(202) 638-2952

Childhelp U.S.A., Inc.
6463 Independence Avenue
Woodland Hills, CA 91370
(818) 347-7280

Children of the Night
1800 N. Highland Avenue, #128
Hollywood, CA 90028
(213) 461-3160

Children's Defense Fund
122 C Street, NW, Suite 400
Washington, DC 20001
(202) 628-8787

Children's Rights Group
693 Mission Street
San Francisco, CA 94105
(415) 495-7283

Contact Center
P.O. Box 81826
Lincoln, NE 68501
(402) 464-0602

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Council for Learning Disabilities
P.O. Box 40303
Overland Park, KS 66204
(913) 492-3840

Department of Education
400 Maryland Avenue
Washington, DC 20202
(202) 732-4576

Family Service Association
of America
11700 West Lake Park Drive
Milwaukee, WI 53224
(414) 359-2111

Foster Grandparent's Program
2500 Martin Luther King
Avenue, S.E.
Washington, DC 20032
(202) 678-4215

Foundation for Children with
Learning Disabilities
99 Park Avenue, 6th Floor
New York, NY 10016
(212) 687-7211

Girl Scouts of the U.S.A.
830 Third Avenue and 51st Street
New York, NY 10022
(212) 940-7500

Information Center for Individuals
with Disabilities
Fort Point Place
27-43 Wormwood Street
Boston, MA 02210-1606
(617) 727-5540

Institute for Social Justice
1024 Elysian Fields
New Orleans, LA 70117
(504) 943-5954

Institute for the Community as
Extended Family
P.O. Box 952
San Jose, CA 95108
(408) 280-5055

International Society for Prevention
of Child Abuse and Neglect
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Interreligious Foundation for
Community Organization
402 W. 145th Street, 3rd Floor
New York, NY 10031
(212) 926-5757

Jack and Jill of America
1065 Gordon Street, SW
Atlanta, GA 30310
(404) 753-8471

The Kaiser Family Foundation
Quadras
2400 Sand Hill Road
Menlo Park, CA 94025
(415) 329-1000

National Alliance for the Prevention
and Treatment of Child Abuse
c/o New York Founding Hospital
590 6th Avenue
New York, NY 10011
(212) 633-9300

National Assembly of National
Voluntary and Social Welfare
Organizations
1319 F Street, NW, Suite 601
Washington, DC 20005
(202) 347-2080

National Association for
Human Development
1620 I Street, NW
Washington, DC 20006
(202) 331-1737

National Association for the
Education of Young Children
1834 Connecticut Avenue, NW
Washington, DC 20009
(202) 232-8777

National Association of Neighborhoods
1651 Fuller, NW
Washington, DC 20009
(202) 332-7766

National Association of Public Child Welfare Administrators
c/o American Public Welfare
810 1st Street, NE, Suite 500
Washington, DC 20002-4205
(202) 682-0106

National Association of the Physically Handicapped
2617 Everett Road
Peninsula, OH 44264
(614) 852-1664

National Association of Secondary School Principals
1904 Association Drive
Reston, VA 22091
(703) 860-0200

National Association of Social Workers
7891 Eastern Avenue
Silver Spring, MD 20910
(301) 565-0333

National Association of Town Watch
7 Wynnewood Road, Suite 215
Wynnewood, PA 19096
(215) 649-7055

National Center for Urban Ethnic Affairs
P.O. Box 33279
Washington, DC 20033
(202) 232-3600

National Committee for Prevention of Child Abuse
332 S. Michigan Avenue, Suite 950
Chicago, IL 60604
(312) 633-3520

National Committee on Youth Suicide Prevention
825 Washington
Norwood, MA 02062-3441
(617) 769-5686

National Community Action Foundation
2100 M Street, NW, Suite 604A
Washington, DC 20037
(202) 775-0223

National Council on Crime and Delinquency
77 Maiden Lane, 4th Floor
San Francisco, CA 94180
(415) 956-5651

National Council on Family Relations
1910 W. County Road B, Suite 147
St. Paul, MN 55113
(612) 633-6933

National Crime Prevention Council
733 15th Street, NW, Suite 540
Washington, DC 20005
(202) 393-7141

National Easter Seal Society
70 East Lake Street
Chicago, IL 60601
(312) 726-6200

National Exchange Club Foundation for the Prevention of Child Abuse
3050 Central Avenue
Toledo, OH 43606
(419) 535-3232

National Governors' Association
Hall of States
444 N. Capitol
Washington, DC 20001
(202) 624-5300

National Information Center for
Handicapped Children and Youth
P.O. Box 1492
Washington, DC 20013
(703) 893-6061

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314
(703) 684-7722

National Network of Runaway and
Youth Services
905 Sixth Street, SW
Washington, DC 20024
(202) 682-4114

National Organization of Adolescent
Pregnancy and Parenting
P.O. Box 2365
Reston, VA 22090
(703) 435-3948

North American Council on
Adoptable Children
P.O. Box 14808
Minneapolis, MN 55414
(612) 333-7692

Odyssey Institute Corporation
817 Fairfield Avenue
Bridgeport, CT 06604
(203) 334-3488

Orphan Foundation of America
P.O. Box 14261
Washington, DC 20044
(202) 861-0762

Parents Anonymous
6733 S. Sepulveda, Suite 270
Los Angeles, CA 90045
(213) 410-9732

Parents Without Partners
8807 Colesville Road
Silver Spring, MD 20910
(301) 588-9354

Perceptions, Inc.
P.O. Box 142
Millburn, NJ 07041
(201) 376-3766

Planned Parenthood Federation
of America
810 Seventh Avenue
New York, NY 10019
(212) 541-7800

Project Volunteer
880 81st Avenue
Oakland, CA 94621
(415) 562-0290

Save the Children Federation
54 Wilton Road
Westport, CT 06880
(203) 226-7271

Southern Association of Children
Under Six
P.O. Box 5403, Brady Station
Little Rock, AR 72215
(501) 663-0353

Southern Mutual Help Association
P.O. Box 850
Jeanerette, LA 70538
(318) 367-3277

SPARK Program
40 Irving Place, Room 94
New York, NY 10003
(212) 477-5442

Time Out to Enjoy
715 Lake Street, #100
Oak Park, IL 60301
(312) 383-9017

U.S. Conference of Mayors
1620 I Street, NW
Washington, DC 20006
(202) 293-7330

Women in Crisis, Inc.
133 West 21st Street
New York, NY 10011
(212) 242-4880

The Youth Project
2335 18th Street, NW
Washington, DC 20009
(202) 483-0030

Youth Suicide National Center
1811 Trousdale Drive
Burlingame, CA 94010
(415) 877-5605

Appendix B

The Regional Alcohol and Drug Awareness Resource (RADAR) Network consists of State clearinghouses, specialized information centers of national organizations, and the Department of Education Regional Training Centers. Each RADAR Network member can offer the public a variety of information services. Check with the representative in your area to find out what services are available.

STATE RADAR NETWORK CENTERS

Alabama
Crystal Jackson
Alabama Department of Mental Health/Mental Retardation
P.O. Box 3710
200 Interstate Park Drive
Montgomery, AL 36193
(205) 271-9258

Alaska
Joyce Paulus
Alaska Council on Prevention of Alcohol and Drug Abuse
7521 Old Seward Highway
Anchorage, AK 99518
(907) 349-6602

American Samoa
Scott Whitney
Department of Human Resources
Social Services Division
Government of American Samoa
Pago Pago, AS 96799
(684) 633-4485

Arizona
Nancy Hanson
Arizona PRC
Extended Education
Arizona State University
Tempe, AZ 85287-1708
(602) 965-9666
FAX: (602) 965-8198

Arkansas
Patsy Wagner
Office on Alcohol and Drug Abuse Prevention
P.O. Box 1437
400 Donaghey Plaza N.
7th and Main Street
Little Rock, AR 72203-1437
(501) 682-6653

***California**
Peggy Blair
State of California Department of Alcohol and Drug Programs
1700 K Street
Sacramento, CA 95814
(916) 327-8447

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* indicates membership on steering committee.

Colorado
Linda M. Garrett
Resource Department
Colorado Alcohol and Drug
Abuse Division
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8201, (303) 331-8248

Warehouse
Attention: Linda Garrett
Division of Central Services
4200 Garfield
Denver, CO 80216

*NPN Representative: Fred Garcia
Colorado Alcohol and Drug Division
4210 E. 11th Avenue
Denver, CO 80220
(303) 331-8001
FAX: (303) 320-1529

Connecticut
Kathleen Senese
Connecticut Clearinghouse
334 Farmington Avenue
Plainville, CT 06062
(203) 793-9791

Delaware
Doris A. Bolt
The Resource Center of the YMCA
of Delaware
11th and Washington Streets
Wilmington, DE 19801
(302) 571-6975

***District of Columbia**
Karen Wright
Washington Area Council on
Alcoholism and Drug Abuse
1232 M Street, NW
Washington, DC 20005
(202) 682-1716

Florida
Cindy Colvin
Florida Alcohol and Drug
Abuse Association
1286 N. Paul Russell Road
Tallahassee, FL 32301
(904) 878-6922, (904) 878-2196

Georgia
Marie Albert
Georgia Prevention Resource Center
Division of Mental Health
878 Peachtree Street, NE, Room 319
Atlanta, GA 30309
(404) 894-4204

Guam
Barbara Benavente
Department of Mental Health and
Substance Abuse
P.O. Box 9400
Tamuning, Guam 96911
(671) 646-9261, (671) 646-9269

Hawaii
Dr. Ken Willinger
Alcohol and Drug Division
State of Hawaii Department of Health
1270 Queen Emma Street, Suite 706
Honolulu, HI 96813
(808) 548-4280

Idaho
Richard Baylis/Jack Quast
Health Watch Foundation
1101 W. River, Suite 270
Boise, ID 83702
(208) 345-4234, (800) 733-0328

Illinois
Carolyn Murphy
Prevention Resource Center Library
822 South College
Springfield, IL 62704
(217) 525-3456

Warehouse
c/o Millers Storage
417 N. 4th Street
Springfield, IL 62702

Indiana
Susan Billingham
Indiana Prevention Resource Center
for Substance Abuse
840 State Road, 46 Bypass
Room 110
Indiana University
Bloomington, IN 47405
(812) 855-1237

***Iowa**
Tressa Youngbear
Iowa Substance Abuse
Information Center
Cedar Rapids Public Library
500 First Street, SE
Cedar Rapids, IA 52401
(319) 398-5133

Warehouse
American Storage
c/o T. Youngbear
401 First Street, SE
Cedar Rapids, IA 52401

Kansas
Judy Donovan
Kansas Alcohol and Drug
Abuse Services
Department of Social and
Rehabilitative Services
300 S.W. Oakley
Topeka, KS 66606
(913) 296-3925

Kentucky
Dianne Shuntich
Drug Information Service
for Kentucky
Division of Substance Abuse
275 East Main Street
Frankfort, KY 40621
(502) 564-2880

Warehouse
Pamphlet Library
Frankfort Habilitation
3755 U.S. 127 South
Frankfort, KY 40601

Louisiana
Sanford W. Hawkins, Sr.
Division of Alcohol and Drug Abuse
P.O. Box 3868
Baton Rouge, LA 70802-3868
(504) 342-9352

Street Address
1201 Capitol Access Road
4th Floor, East
Baton Rouge, LA 70821-3868

Maine
Earle Simpson
Maine Alcohol and Drug Abuse
Clearinghouse
Office of Alcoholism and Drug
Abuse Prevention
State House Station #11
Augusta, ME 04333
(207) 289-2781

Maryland
Standola Reynolds
Alcohol and Drug Abuse
Administration
Department of Health and
Mental Hygiene
201 W. Preston Street, 4th Floor
Baltimore, MD 21201
(301) 225-6543

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* indicates membership on steering committee.

***Massachusetts**
Donna Woods
Massachusetts Information and
Referral Service
675 Massachusetts Avenue
Cambridge, MA 02139
(617) 445-6999

Michigan
Gail Johnsen
Michigan Substance Abuse and
Traffic Safety Information Center
2409 East Michigan
Lansing, MI 48912-4019
(517) 482-9902

Warehouse
Stop 'N Lock
Attention: Gail Johnsen
Michigan Substance Abuse
Clearinghouse
1140 Ramada Drive
Lansing, MI 48910

Minnesota
Mary F. Scheide
Minnesota Prevention
Resource Center
2829 Verndale Avenue
Anoka, MN 55303
(612) 427-5310 or (800) 233-9513

Mississippi
Anne Goforth
Mississippi Department of
Mental Health
Division of Alcoholism and
Drug Abuse
1101 Robert E. Lee Building,
9th Floor
239 N. Lamar Street
Jackson, MS 39207
(601) 359-1288

Missouri
Randy Smith/Genie Massic
Missouri Division of Alcohol and
Drug Abuse
1915 Southridge Drive
Jefferson City, MO 65109
(314) 751-4942

Montana
Nancy Tunnicliff
Department of Institutions
Chemical Dependency Bureau
1539 - 11th Avenue
Helena, MT 59620
(406) 444-2878

Nebraska
Laurel Erickson
Alcoholism and Drug Abuse Council
of NE
215 Centennial Mall South
Room 412
Lincoln, NE 68508
(402) 474-0930, (402) 474-1992

*NASADAD Representative:
Malcolm Heard
Division of Alcoholism and
Drug Abuse
P.O. Box 94728
Lincoln, NE 68509
(402) 471-2851

Street Address
801 West Van Dorn
2nd Building, 2nd Floor
Lincoln, NE 68522

Nevada
Ruth Lewis
Bureau of Alcohol and Drug Abuse
505 E. King Street, Suite 500
Carson City, NV 89710
(702) 885-4790

New Hampshire
Mary Dube
New Hampshire Office of Alcohol and
Drug Abuse Prevention
6 Hazen Drive
Concord, NH 03301
(603) 271-6100

New Jersey
Mark J. Byrne/Barry Hantman
New Jersey State Department
of Health
Division of Alcoholism and
Drug Abuse
129 E. Hanover Street
Trenton, NJ 08625
(609) 292-0729
FAX: (609) 292-3816

New Mexico
Courtney Cook
Health and Environment
Department/BHSD/
Substance Abuse Bureau
1190 St. Francis Drive
Harold Runnles Building, Room 3350
Santa Fe, NM 87504-0968
(505) 827-2601
FAX: (505) 827-0097

New York
Leslie S. Connor/Laura Perry
New York Division of Alcoholism
and Alcohol Abuse
194 Washington Avenue
Albany, NY 12210
(518) 473-3460

*Judith M. Lukin
Resource Center Narcotic and Drug
Research, Inc.
11 Beach Street, 2nd Floor
New York, NY 10013
(212) 966-8700, ext. 107

North Carolina
Betty Lane
North Carolina Alcohol/
Drug Resource Center
3109 A University Drive
Durham, NC 27707-3703
(919) 493-2881

***North Dakota**
Michele Edwards
North Dakota Prevention
Resource Center
1839 East Capitol Avenue
Bismarck, ND 58501
(701) 224-3603

Ohio
Deborah Chambers
Ohio Department of Alcohol and Drug
Addiction Services
2 Nationwide Plaza, 12th Floor
Columbus, OH 43216
(614) 466-6379

Oklahoma
Jan Hardwick
Oklahoma State Department of
Mental Health
P.O. Box 53277
Oklahoma City, OK 73152
(405) 271-8755
FAX: (405) 271-8755

Street Address
1200 N.E. 13th, 2nd Floor
Oklahoma City, OK 73117

***Oregon**
Sue Ziglinski
Oregon Drug and Alcohol
Information
100 North Cook
Portland, OR 97227
(800) 237-7808, ext. 3673
(503) 280-3673
FAX: (503) 280-4621

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* indicates membership on steering committee.

Pennsylvania
Gwen Miller
ENCORE
Pennsylvania Department of Health
Department of Health Programs
P.O. Box 2773
Harrisburg, PA 17105
(717) 787-2606, (717) 787-9761

Street Address
Health and Welfare Building,
Room 923
6th and Foster Street
Harrisburg, PA 17120

Puerto Rico
Alma Negron
Department of Anti-Addiction
Services
414 Barbosa Avenue
Apartado 21414—Rio Piedras Station
Rio Piedras, PR 00928-1414
(809) 763-3133
FAX: (809) 765-5895

Rhode Island
Bette Anne McHugh
Rhode Island Division of
Substance Abuse
P.O. Box 20363
Louis Pasteur Building
Howard Avenue
Cranston, RI 02920
(401) 464-2140, (401) 464-2141

***South Carolina**
Anne Goforth
South Carolina Commission on
Alcohol and Drug Abuse
The Drug Store Information
Clearinghouse
3700 Forest Drive, Suite 300
Columbia, SC 29204
(803) 734-9559

South Dakota
Bob Anderson/Diana Knox
Department of Health
Division of Alcohol and Drug Abuse
700 Governors Drive
Kniep Building
Pierre, SD 57501
(605) 773-3123

Tennessee
Sharon Crockett
Tennessee Alcohol and Drug
Association
545 Mainstream Drive, Suite 404
Nashville, TN 37228
(615) 244-7066
FAX: (615) 255-3704

***Texas**
Carlene Phillips/Maggie Houston
Texas Commission on Alcohol and
Drug Abuse Resource Center
720 Brazos Street
Suite 307
Austin, TX 78729
(512) 867-8700
FAX: (512) 480-0679

Street Address
1705 Guadalupe
Austin, TX 78701-1214

Utah
Sherry Young
Utah State Division of
Substance Abuse
120 N. 200 West, 4th Floor
Salt Lake City, UT 84145-0500
(801) 538-3939

Vermont
Pam Fontaine
Office of Alcohol and Drug
Abuse Programs
103 South Main Street
Waterbury, VT 05676
(802) 241-2178

Virginia
Jane Skaggs
Virginia Department of MH/MR/SA
109 Governor Street
Richmond, VA 23219
(804) 786-3909

Virgin Islands
Division of Mental Health
Prevention Unit
c/o Marcia Jameson
Charles Harwood Hospital
Complex, Richmond
St. Croix, VI 00820
(809) 773-8443

Washington
Mary Goehring
Washington State Substance
Abuse Coalition (WSSAC)
14700 Main Street
Bellevue, WA 98007
(206) 747-9111

West Virginia
Shirley A. Smith
West Virginia Library Commission
Cultural Center
Charleston, WV 25305
(304) 348-2041

Wisconsin
Douglas White
Wisconsin Clearinghouse
315 N. Henry Street
Madison, WI 53703
(608) 263-2797, (608) 263-6886
FAX: (608) 262-0123

Wyoming
Sue Rardin
Wyoming CARE Program
P.O. Box 3425
University of Wyoming
Laramie, WY 82071
(307) 766-4119

Street Address
Biological Science Building
Room 135
Laramie, WY 82071

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* indicates membership on steering committee.

SPECIALTY CENTERS

These organizations offer a variety of information services. They also serve both national and international audiences.

Arizona
Travis Jackson
Indian Health Service
Colorado River Service
Route 1, Box 12
Parker, AZ 85344
(602) 669-2137
FAX: (602) 669-5450

California
Christina Miller
Prevention Research Center Library
2532 Durant Avenue
Berkeley, CA 94704
(415) 486-1111

Nancy Kaihatsu/Tom Colhurst
Program on Alcohol and Drug Issues
University of California, San Diego
UCSD Extension, X-001
La Jolla, CA 92093-0176
(619) 534-6331

*Dr. Ford Kuramoto
Programs of National Significance Projects
National Asian Pacific American Families Against Substance Abuse, Inc. (NAPAFASA)
420 East Third Street, Suite 909
Los Angeles, CA 90013
(213) 617-8277
FAX: (213) 617-2012

Elva Yanez
Resource Center
Marin Institute for the Prevention of Alcohol and Other Drug Problems
24 Belvedere Street
San Rafael, CA 94901
(415) 456-5692
FAX: (415) 456-0491

Angela Dugan
National Association for Children of Alcoholics (NACoA)
31582 Coast Highway, Suite B
South Laguna, CA 92677
(714) 499-3889

Andrea L. Mitchell
Alcohol Research Group
Medical Research Institute of San Francisco at Pacific Presbyterian Medical Center
2000 Hearst Avenue
Berkeley, CA 92176
(415) 642-5208

Ford S. Hatamiya
Multicultural Training Resource Center
1540 Market Street, Suite 320
San Francisco, CA 94102
(415) 861-2142

Canada
Margy Chan
Addiction Research Foundation Library
33 Russell Street
Toronto, Ontario
Canada M5S 2S1
(416) 595-6144
FAX: (416) 595-5017

Jill Austin
Canadian Centre on Substance Abuse
112 Kent Street, Suite 480
Ottawa, Ontario
Canada K1P 5P2
(613) 235-4048

District of Columbia
*Maria Ortiz/Helen Munoz
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
1030 - 15th Street, NW, Suite 1053
Washington, DC 20005
(202) 371-2100

George Hacker
Advocacy Institute
1730 Rhode Island Avenue, NW, Suite 600
Washington, DC 20036
(202) 659-8457

Ruth Marie Conolly
Interamerican Documentation Center
Interamerican Drug Information System
OAS/CICAD
1889 F Street, NW, 8th Floor
Washington, DC 20006
(202) 458-3809

Patricia M. Dietz, M.P.H.
The National Network of Runaway and Youth Services, Inc.
1400 Eye Street, NW, Suite 330
Washington, DC 20005
(202) 682-4114

Georgia
Paula Kemp
National Drug Information Center of Families in Action
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345
(404) 934-6364

*Beverly E. Allen
Multi-Media Center
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta, GA 30310-1495
(404) 752-1530

Maryland
Leonore Burts
National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
(800) 458-5231

Street Address
1600 Research Boulevard
Aspen Building
Rockville, MD 20850

Glen Holley
Clearinghouse on Drugs and Crime
1600 Research Boulevard
Rockville, MD 20850
(301) 251-5531

Minnesota
David Grant
Institute on Black Chemical Abuse Resource Center
2616 Nicollet Avenue, South
Minneapolis, MN 55407
(612) 871-7878
FAX: (612) 871-2567

New Hampshire
Jean Kinney
Project CORK
Dartmouth University
9 Maynard Street
Hanover, NH 03756
(603) 646-7540

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* indicates membership on steering committee.

New Jersey
Cathy Weglarz
Center of Alcohol Studies
Rutgers University
Smithers Hall, Busch Campus
Piscataway, NJ 08855-0969
(201) 932-4443

New York
Jose Luis Rodriguez
Hispanic Information and
Telecommunication Network
449 Broadway, 3rd Floor
New York, NY 10013
(212) 966-5660
FAX: (212) 966-5725

Jeff Hon
National Council on Alcoholism
and Drug Dependence, Inc.
12 West 21st Street
New York, NY 10010
(212) 206-6770

Pennsylvania
Penny Howe
Chemical People Institute
1615 Penn Avenue
Pittsburgh, PA 15222
(412) 391-0900

Puerto Rico
Lcdo. Luis Rivera Roman
Aesor del Gobernador
La Fortaleza
San Juan, PR 00901
(809) 721-7000, (809) 721-4011

Virginia
Richard Bickerton
Employee Assistance
Professionals, Inc.
4601 North Fairfax Drive, Suite 1001
Arlington, VA 22203
(703) 522-6272

Paula Carney
WIC, Program Development Section,
Supplemental Food Program
Division
3101 Park Center Drive, Room 1017
Alexandria, VA 22302
(703) 756-3730

***Washington**
Nancy Sutherland
University of Washington
Alcoholism and Drug Abuse
Institute Library
3937 15th Avenue, NE, NL-15
Seattle, WA 98105
(206) 543-0937

DEPARTMENT OF EDUCATION REGIONAL TRAINING CENTERS

The regional training centers provide training assistance and expertise to local schools to prevent and reduce alcohol and other drug use by students.

Illinois
Donna Wagner
Midwest Regional Center for Drug Free Schools and Communities
1990 Spring Road, 3rd Floor
Oakbrook, IL 60521
(708) 571-4710

Kentucky
Nancy Cunningham
Southeast Regional Center for Drug Free Schools and Communities
Room 315, Belknap Campus
Louisville, KY 40292
(502) 588-6411

New York
Karen Means
Evaluation and Dissemination
Northeast Regional Center for Drug Free Schools and Communities
12 Overtone Avenue
Sayville, NY 11782
(516) 589-7022

Oklahoma
Margretta Bartlett
Southwest Regional Center for Drug Free Schools and Communities
University of Oklahoma
555 Constitution Avenue, Room 138
Norman, OK 73037
(405) 325-1454

***Oregon**
Kathy Laws
Western Center for Drug Free Schools and Communities
Northwest Regional Educational Lab
101 SW Main Street, Suite 500
Portland, OR 97204
(503) 275-9500

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* indicates membership on steering committee.

170

Appendix C

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

Alabama
(c) James V. Laney, Director
Division Substance Abuse Services
AL Department of Mental Health
and Mental Retardation
200 Interstate Park Drive
P.O. Box 3710
Montgomery, AL 36193
(205) 270-4650
FAX: (205) 240-3195

Alaska
(c) Loren Jones, Director
Division of Alcoholism and
Drug Abuse
AK Department of Health and
Social Services
P.O. Box H-05-F
Juneau, AK 99811-0607
(907) 586-6201
FAX: (907) 586-1061

Arizona
(c) Ed Zborower, Program
Representative for Alcoholism
and Drug Abuse
AZ Department of Health Services
Office of Community Behavioral
Health
2632 East Thomas
Phoenix, AZ 85016
(602) 255-1025 or 1030
FAX: (602) 255-1042

Arkansas
(c) Paul T. Behnke, Director
AR Office of Alcohol and Drug
Abuse Prevention
Donaghey Plaza North, Suite 400
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 682-6650
FAX: (501) 682-6610

California
(c) Andrew M. Mecca, Dr. P.H.,
Chairman
Governor's Policy Council on Drug
and Alcohol Abuse
1700 K Street, 5th Floor
Executive Office
Sacramento, CA 95814-4037
(916) 445-1943
FAX: (916) 323-5873

Colorado
(c) Robert Aukerman, Director
Alcohol and Drug Abuse Division
CO Department of Health
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8201
FAX: (303) 320-1529

(a) Single Alcoholism Agency
(b) Single Drug Abuse Agency
(c) Combined Alcohol and Drug Abuse Agency

Connecticut
(c) Donald J. McConnell,
Executive Director
CT Alcohol and Drug
Abuse Commission
999 Asylum Avenue, 3rd Floor
Hartford, CT 06105
(203) 566-4145
FAX: (203) 566-6055

Delaware
(c) Neil Meisler, Director
DE Division of Alcoholism, Drug
Abuse and Mental Health
1901 N. DuPont Highway
Newcastle, DE 19720
(302) 421-6101
FAX: (302) 421-6086

District of Columbia
(c) Simon Holliday, Chief
DC Health Planning and Development
1660 L Street, NW
Washington, DC 20036
(202) 673-7481
FAX: (202) 727-2386

Florida
(c) Benjamin F. Williams
Deputy Assistant Secretary
Alcohol and Drug Abuse
FL Department of Health and
Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-0900
FAX: (904) 487-2239

Georgia
(c) Patricia A. (Pam) Redmond
Director, GA Alcohol and Drug
Services Section
878 Peachtree Street, NE, Suite 318
Atlanta, GA 30309
(404) 894-6352
FAX: (404) 853-9065

Hawaii
(c) Elaine Wilson, Division Chief
Alcohol and Drug Abuse Division
HI Department of Health
P.O. Box 3378
Honolulu, HI 96801
(808) 586-3962
FAX: (808) 586-4016

Idaho
(c) Ken Patterson, Administrator
Division of Family and Children
and Services
ID Department of Health and Welfare
450 West State Street, 7th Floor
Boise, ID 83720
(208) 334-5935
FAX: (208) 334-5694

Illinois
(c) James Long, Director
IL Department of Alcoholism and
Substance Abuse
100 West Randolph Street,
Suite 5-600
Chicago, IL 60601
(312) 814-3840
FAX: (312) 814-2419

Indiana
(c) Johnie Underwood, Director
Division of Addiction Services
IN Department of Mental Health
117 East Washington Street
Indianapolis, IN 46204-3547
(317) 232-7816
FAX: (317) 232-7948

Iowa
(c) Janet Zwick, Director
Division of Substance Abuse and
Health Promotion
IA Department of Public Health
Lucas State Office Building, 4th Floor
Des Moines, IA 50319
(515) 281-3641
FAX: (515) 281-4958

Kansas
(c) Andrew O'Donovan
Commissioner
KS Alcohol and Drug Abuse Services
300 SW Oakley
Biddle Building
Topeka, KS 66606-1861
(913) 296-3925
FAX: (913) 296-0511

Kentucky
(c) Michael Townsend, Director
Division of Substance Abuse
KY Department of MH - MR Services
275 East Main Street
Frankfort, KY 40621
(502) 564-2880
FAX: (502) 564-3844

Louisiana
(c) Robert A. Perkins, Ph.D., Director
Division of Alcohol and Drug Abuse
Department of Health and Hospitals
1201 Capitol Access Road
P.O. Box 3868
Baton Rouge, LA 70821-3868
(504) 342-9354
FAX: (504) 342-4419

Maine
(c) Ronald Speckmann
Acting Director
Office of Substance Abuse
State House Station #42
24 Stone Street
Augusta, ME 04333
(207) 289-2595
FAX: (207) 626-5555

Maryland
(c) Rick Sampson, Director
MD State Alcohol and Drug
Abuse Administration
201 West Preston Street
Baltimore, MD 21201
(301) 225-6925
FAX: (301) 225-5305

Massachusetts
(c) Dennis McCarty, Director
MA Division of Substance
Abuse Services
150 Tremont Street
Boston, MA 02111
(617) 727-8614
FAX: (617) 727-9288

Michigan
(c) Gerald DeVoss,
Deputy Administrator
Office of Substance Abuse Services
MI Department of Public Health
2150 Apollo Drive
P.O. Box 30206
Lansing, MI 48909
(517) 335-8809
FAX: (517) 335-8837

(a) Single Alcoholism Agency
(b) Single Drug Abuse Agency
(c) Combined Alcohol and Drug Abuse Agency

Minnesota
(c) Cynthia Turnure, Ph.D., Director
Chemical Dependency
Program Division
MN Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3823
(612) 296-4610
FAX: (612) 296-6244

Mississippi
(c) Anne D. Robertson, Director
Division of Alcohol and Drug Abuse
MS Department of Mental Health
Robert E. Lee State Office Building
11th Floor
Jackson, MS 39201
(601) 359-1288

Missouri
(c) Sue Giles, Director
Division of Alcohol and Drug Abuse
MO Department of Mental Health
1706 E. Elm Street
Jefferson City, MO 65109
(314) 751-4942
FAX: (314) 751-7814

Montana
(c) Robert Anderson, Administrator
Alcohol and Drug Abuse Division
Montana Department of Institutions
Helena, MT 59601
(406) 444-2837
FAX: (406) 444-4920

Nebraska
(c) Malcolm Heard, Director
Division of Alcoholism and
Drug Abuse
NE Department of Public Institutions
P.O. Box 94728
Lincoln, NE 68509-4728
(402) 471-2851, Ext. 5583
FAX: (402) 479-5145

Nevada
(c) Liz Breshears, Chief
Bureau of Alcohol and Drug Abuse
NV Department of Human Resources
505 East King Street
Carson City, NV 89710
(702) 687-4790
FAX: (702) 687-4733

New Hampshire
(c) Geraldine Sylvester, Director
NH Office of Alcohol and Drug
Abuse Prevention
Health and Welfare Building
Hazen Drive
Concord, NH 03301
(603) 271-6104
FAX: (603) 271-5051

New Jersey
(c) Richard Russo, MSPH
Assistant Deputy Commissioner
Division of Alcoholism and
Drug Abuse
NJ Department of Health
CN 360, Room 805
Trenton, NJ 08625-0360
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177

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